



# TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)  
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645  
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

Texas Health Allen

**Respondent Name**

Utica Mutual Insurance Co

**MFDR Tracking Number**

M4-18-3183-01

**Carrier's Austin Representative**

Box Number 01

**MFDR Date Received**

May 1, 2018

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Patient contacted us on 1/5/18 and provided WC information..."

**Amount in Dispute:** \$324.55

### RESPONDENT'S POSITION SUMMARY

The Austin carrier representative for Utica Mutual Insurance Co is JT Parker & Associated LLC. JT Parker & Associates acknowledged receipt of the copy of this medical fee dispute on May 8, 2018.

28 Texas Administrative Code §133.307 states, in relevant part:

- (d) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
  - (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile **within 14 calendar days after the date the respondent received the copy of the requestor's dispute** [emphasis added]. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

Review of the documentation finds that no response has been received on behalf of Utica Mutual Insurance Co from JT Parker & Associates to date. The division concludes that Utica Mutual Insurance Co failed to respond within the timeframe required by §133.307(d)(1). For that reason the division will base its decision on the information available.

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 23, 2017	Outpatient Hospital Services	\$324.55	\$324.55

## **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the workers' compensation medical bill filing deadlines.
3. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 29 – The time limit for filing has expired

### **Issues**

1. Are the insurance carrier's reasons for denial of payment supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

### **Findings**

1. The requestor is seeking \$324.55 for outpatient hospital services provided on September 23, 2017. The insurance carrier denied disputed services with claim adjustment reason code 29 – "The time limit for filing has expired." 28 Texas Administrative Code §134.20(b) states in pertinent part,

(b) Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill.

Review of the submitted information found the requestor indicates they were notified on January 5, 2018 of the workers compensation coverage and a medical bill was created and submitted to the carrier on January 15, 2018. The carrier acknowledged receipt of the claim on January 15, 2018. This date is within 95 days of the notification of the correct workers compensation carrier. The carrier's denial is not supported. The services in dispute will be reviewed per applicable rules and fee guidelines.

2. This dispute regards outpatient hospital services with reimbursement subject to the division's *Hospital Facility Fee Guideline—Outpatient*, at 28 Texas Administrative Code §134.403 (f)(1) which requires that the sum of the Medicare facility specific amount and any applicable outlier payment be multiplied by 200 percent, unless a facility or surgical implant provider requests separate payment of implantables but implantables are not part of this dispute. The MAR will be calculated per provision stated above.
3. The Medicare Claims Processing Manual, Chapter 4 section 10.1.1 and 10.2 at [www.cms.gov](http://www.cms.gov) states in pertinent parts,

*An OPPS payment status indicator is assigned to every HCPCS code. The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule.*

*Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC.*

Reimbursement for the disputed services is calculated as follows:

- Procedure code 96372 has status indicator S, defined as procedures not subject to reduction. This code is assigned APC 5692. The OPSS Addendum A rate is \$53.17, multiplied by 60% for an unadjusted labor amount of \$31.90, in turn multiplied by the facility wage index of 0.9794 for an adjusted labor amount of \$31.24. The non-labor portion is 40% of the APC rate, or \$21.27. The sum of the labor and non-labor portions is \$52.51. The Medicare facility specific amount of \$52.51 is multiplied by 200% for a MAR of \$105.02.
  - Procedure code 99282 has status indicator J2, for outpatient visits (subject to comprehensive packaging if 8 or more hours observation billed) but as observation hours are not part of this medical bill, the criteria for comprehensive packaging is not met. This code is assigned APC 5022 which has a status indicator of V. The OPSS Addendum A rate is \$111.47, multiplied by 60% for an unadjusted labor amount of \$66.88, in turn multiplied by the facility wage index of 0.9794 for an adjusted labor amount of \$65.50. The non-labor portion is 40% of the APC rate, or \$44.59. The sum of the labor and non-labor portions is \$110.09. The Medicare facility specific amount of \$110.09 is multiplied by 200% for a MAR of \$220.18.
4. The total recommended reimbursement for the disputed services is \$325.20. The requestor is seeking reimbursement of \$324.55. This amount is recommended.

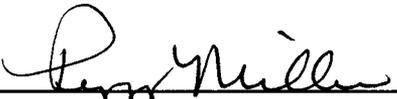
**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$324.55.

***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$324.55, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

  
Signature

Peggy Miller  
Medical Fee Dispute Resolution Officer

August 9, 2018  
Date

***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (form DWC045M)** in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim. The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**