TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Hendrick Medical Center

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-25-0321-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
October 8, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 28, 2023	72146	$3059.04	$967.74
December 28, 2023	72148	$3024.78	$0.00
	Total	$6083.82	$967.74

Requestor's Position

"This bill was denied for timely filing. This bill was initially faxed to Sedgwick at 859-264-4061 on 02/08/2024. When HENDRICK MEDICAL CENTER BROWNWOOD inquired on bill status, Sedgwick advised that the claim was no longer handled by Sedgwick and that Gallagher Bassett was now the bill review company on 04/10/2024. After receiving notice that the carrier had changed on 04/10/2024 the bill was submitted to Gallagher Bassett on 4/11/24 and per section 408.0272 of the labor code."

Amount in Dispute: $6083.82

Respondent's Position

The Austin carrier representative for Indemnity Insurance Co of North America is Downs & Stanford. The representative was notified of this medical fee dispute on October 15, 2024.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available

information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

Findings and Decision

Authority

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

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.20 sets the billing requirements of medical bills.
3. Texas Labor Code 408.0272 indicates exceptions to the timely filing deadline.
4. 28 TAC §134.600 sets out prior authorization requirements.
5. 28 TAC §134.403 sets out the rules and fee guidelines for outpatient hospital services.

Denial Reasons

- 29/90096 – The time limit for filing has expired.
- 00663 – Reimbursement has been calculated according to State fee schedule guidelines.
- 4271 – Per TX Labor Code Sec. 408.027, providers must submit bills to payors within 95 days of the date of service.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 193/90563 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 31065 – This service was not pre-authorized in conformance with TWCC Rule 134.600.

Issues

1. Did the requestor support timely submission of the claim?
2. Was prior authorization required?
3. What rule is applicable to reimbursement?
4. Is the requestor entitled to payment of disputed services?

Findings

1. The requestor is seeking payment of outpatient imaging services. The insurance carrier denied for untimely claim submission.

   DWC Rule 28 TAC §102.4 (h) Unless the great weight of evidence indicates otherwise, written communications will be deemed to have been sent on:

   (1) the date received if sent by fax, personal delivery, or electronic transmission; or

   (2) the date postmarked if sent by mail through United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent must be the next previous day that is not a Sunday or legal holiday.

   DWC Rule 28 TAC §133.20 (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.

   Texas Labor Code 408.0272. (b) states in pertinent part,

   (b) Notwithstanding Section 408.0272, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.0272(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:

   (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:

      (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;

      (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or

      (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title;

   (2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

   Review of the submitted documentation found a screen shot of correspondence between requestor and Sedgwick that confirms the requestor was notified of the correct workers compensation carrier, (Gallagher Bassett). This conversation is dated April 10, 2024.

   Additional review of the submitted medical documentation found evidence of the delivery of an item via USPS to Gallagher Bassett on April 17, 2024.

   Based on this review the requestor has supported timely submission of the medical bill to the correct workers' compensation carrier after they were notified of correct carrier.

2. The insurance carrier denied the reconsideration stating a prior authorization was required but not obtained. DWC Rule 134.600 (p)(8) states in pertinent part, "Non-emergency health care requiring preauthorization includes: unless otherwise specified in this subsection, a repeat individual diagnostic study." The information made known to the division does not indicate this was a repeat study. The insurance carrier's denial for lack of prior authorization is not supported. The disputed services will be reviewed by applicable DWC rules and fee guidelines.

3. DWC Rule 28 TAC §134.403 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.1. Specifically, Payment Status Indicators and Ambulatory Payment Category (APC).

DWC Rule 28 TAC §134.403 (e)(2) states in pertinent part, regardless of billed amount, if no contracted fee schedule exits that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section including any applicable outlier payment amounts and reimbursement for implantables.

DWC Rule 28 TAC §134.403 (f) states in pertinent part the reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*.

The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by: (A) 200 percent; unless (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent. Review of the submitted medical bill found a request for implants is not applicable.

The Medicare facility specific amount is calculated when the APC payment rate is multiplied by 60% to determine the labor portion. This amount is multiplied by the facility wage index for the date of service. The non-labor amount is determined when the APC payment rate is multiplied by 40%. The sum of the labor portion multiplied by the facility wage index and the non-labor portion determines the Medicare specific amount. Review of the submitted medical bill and the applicable fee guidelines referenced above are shown below.

- Procedure code 72146 and 72148 have status indicator Q3, for conditionally packaged codes paid as a composite if OPPS criteria are met. As composite criteria are met these codes are assigned APC 8007 – MRI and MRA without contract composite.

  The OPPS Addendum A rate is $527.17 multiplied by 60% for an unadjusted labor amount of $316.30, in turn multiplied by facility wage index 0.8631 for an adjusted labor amount of $273.00.

  The non-labor portion is 40% of the APC rate, or $210.87.

  The sum of the labor and non-labor portions is $483.87.

  The Medicare facility specific amount is $483.87 multiplied by 200% for a MAR of $967.74.

4. The total recommended reimbursement for the disputed services is $967.74. The insurance carrier paid $0.00. The amount due is $967.74. This amount is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that Indemnity Insurance Co of North America must remit to Hendrick Medical Center $967.74 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 30, 2025 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.