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
National Interstate Insurance Co.

MFDR Tracking Number
M4-25-1623-01

Carrier's Austin Representative
Box Number 6

DWC Date Received
March 18, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 15, 2024	Pharmacy	$15.12	
May 15, 2024	Q9967	$297.00	
May 15, 2024	36415	$51.04	
May 15, 2024	80053	$641.68	
May 15, 2024	83690	$323.29	
May 15, 2024	84484	$381.34	
May 15, 2024	85025	$226.84	
May 15, 2024	85610-QW	$250.25	
May 15, 2024	85730	$305.66	
May 15, 2024	86850	$513.87	
May 15, 2024	86901	$513.87	
May 15, 2024	71260	$6,373.39	
May 15, 2024	72125	$6,062.74	
May 15, 2024	70450	$4,904.39	
May 15, 2024	70486-59	$4,997.14	
May 15, 2024	74177	$9,511.93	
May 15, 2024	96374	$530.99	
May 15, 2024	99285-25	$7,624.48	
May 15, 2024	J0131	$458.41	
May 15, 2024	J3010	$17.82	

May 15, 2024	86900	$513.87	
	Total:	$44,515.12	$2,325.38

Requestor's Position

"NATIONAL INTERSTATE denied this bill due to timely filing expired. This bill was initially submitted to the patients HI BCBS and paid on 5/30/2024. On 8/13/2024 the adjuster … called HENDRICK HEALTH SYSTEM to provide claim and billing details. Please note that HENDRICK HEALTH SYSTEM submitted this bill within 95 days of notice that the bill was sent to the wrong carrier per Labor Code Title 5. Chapter 408, section 408.0272. The denial was appealed and timely filing denial wrongfully upheld."

Amount in Dispute: $44,515.12

Respondent's Position

"After review, National Interstate Ins. Co. believes that the bill at issue was correctly audited, and request that the agency render a decision accordingly."

Response submitted by: Stone, Laughlin, Swanson

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 out requirements of timely medical bill submission.
3. 28 TAC §134.403 sets out the fee guidelines for outpatient hospital services.

Denial Reasons

The insurance carrier denied the disputed service(s) with the following claim adjustment codes:

- 29 - The time limit for filing has expired.
- 193 - Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
- Comment: The documentation submitted does not support proof of timely filing.

Issues

1. Is the insurance carrier's reason for denial of payment for the disputed services supported?
2. What rules apply to the reimbursement of the disputed services?
3. Is the requestor entitled to reimbursement for the services in dispute?

Findings

1. This dispute involves denial of payment for emergency room services rendered on May 15, 2024. A review of the explanation of benefits (EOB) documents submitted finds that the insurance carrier denied payment for the disputed services based on timely filing period had expired.

   28 TAC §133.20, which sets out requirements of timely medical bill submission, 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…"

   Texas Labor Code §408.0272(b) sets out certain exceptions for untimely submission of a claim, states "(b) Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(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; or (2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider."

   A review of the documentation submitted finds evidence to support that the claim was originally submitted in error to the injured employee's health insurance carrier prior to 95 days from the disputed date of service. The evidence submitted further supports that the health care provider then submitted the medical bill to the correct workers' compensation insurance carrier prior to the 95th day after the date the health care provider was notified of the erroneous submission of the medical bill.

   DWC finds that the submitted evidence supports the exception for the untimely submission of the medical claim set out in Texas Labor Code §408.0272(b)(1)(A). Therefore, the insurance carrier's reason for denial of payment for the disputed services is not supported.

2. This dispute involves non-payment for emergency room services rendered on May 15, 2024, in an emergency department of a general acute care hospital.

   DWC finds that Rule 28 TAC §134.403 applies to the services in dispute and that 28 TAC §134.403(d) requires Texas workers' compensation system participants to apply Medicare payment policies in effect on the date of service for the coding, billing, reporting and reimbursement of professional health care services.

   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 the billed amount, if no contracted fee schedule exists that complies with Labor Code §413.011, reimbursement shall be 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*.

3. The requestor is seeking reimbursement for emergency room services rendered on May 15, 2024. Because the insurance carrier's reason for denial is not supported, DWC finds that the requestor is entitled to reimbursement.

   In accordance with 28 TAC §134.403, 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. The submitted medical bill did not contain implant charges.

   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 to yield the adjusted labor amount. The non-labor amount is determined when the APC payment rate is multiplied by 40%. The sum of the adjusted labor amount and the non-labor amount determines the Medicare specific amount. A review of the disputed services, the submitted medical bill and the applicable fee guidelines referenced above are shown below.

   - Procedure code 96374 has a status indicator of S. This service is paid under OPPS; payment is made through a separate APC. Procedure code 96374 is described as level 3 drug administration and has an APC of 5693. Review of Addenda A at www.cms.gov for the disputed date of service indicates a payment amount of $204.22.
   - Procedure codes 86850, 86901, and 86900 have a status indicator of Q1. These services

are packaged if billed on same date of service as HCPCS assigned status indicator "S", "T", "V". These services are packaged into the primary "V" procedure code shown below.

- Procedure codes 36415, 80053, 83690, 84484, 85025, 85610, and 85730 have a status indicator of Q4 which indicates packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "J1", "J2", "S", "T", "V", "Q1", "Q2", or "Q3". These services are packaged into the primary "V" procedure code shown below.

- Procedure codes 72125, 70450, 70486, 71260 and 74177 describe computed tomography (CT) scans with contrast and without contrast. These codes have a status indicator Q3 which indicates payment based on OPPS composite-specific payment criteria. In accordance with Medicare payment policies, certain codes may be grouped together for reimbursement as a "composite" APC when they occur together on the same claim with the same date of service (SI = Q3). Composite APCs provide a single payment for a comprehensive diagnostic and/or treatment service that is defined, for purposes of the APC, as a service typically reported with multiple HCPCS codes. More information on this topic can be found at Integrated OCE (IOCE) CMS Specifications V25.1, effective April 1, 2024. When the composite criteria for a group are met, the primary code is assigned the composite APC and status indicator for payment; reimbursement is packaged into a single payment based on the highest relative value weight and payment rate for specific categories of services. In this case, the APC assigned to CT scans with contrast, which is APC 8006, has the highest relative value weight and payment rate. Review of Addenda A at www.cms.gov for the disputed date of service indicates a composite payment amount of $427.60 for APC 8006.

- Procedure code 99285 is described as Level 5 Type A Emergency Department (ED) Visit and has an APC of 5025. Review of Addenda A at www.cms.gov for the disputed date of service indicates a payment amount of $611.99. This code is the primary "V" code referenced above.

Per a review of the submitted medical bill and the applicable fee guidelines referenced above, reimbursement calculations are outlined below:

Separate APC 5693:

- The OPPS Addendum A, APC rate for the disputed date of service is $204.22.
- The unadjusted labor amount is 60% of the APC rate = $122.532.
- The unadjusted labor amount of $122.532 x the facility wage index 0.8913 = $109.213 adjusted labor amount.
- The non-labor portion is 40% of the APC rate = $81.688.
- The sum of the adjusted labor amount + the non-labor amount = $190.90.
- Therefore, the Medicare facility specific amount = $190.90. This amount is multiplied by 200 percent for a MAR of $381.80.

Composite APC 8006:

- The OPPS Addendum A, APC rate for the disputed date of service is $427.60.

- The unadjusted labor amount is 60% of the APC rate = $256.56.
- The unadjusted labor amount of $256.56 x the facility wage index 0.8913 = $228.672 adjusted labor amount.
- The non-labor portion is 40% of the APC rate = $171.04.
- The sum of the adjusted labor amount + the non-labor amount = $399.71.
- Therefore, the Medicare facility specific amount = $399.71. This amount is multiplied by 200 percent for a MAR of $799.42.

Package APC 5025:

- The OPPS Addendum A, APC rate for the disputed date of service is $611.99.
- The unadjusted labor amount is 60% of the APC rate = $367.194.
- The unadjusted labor amount of $367.194 x the facility wage index 0.8913 = $327.280 adjusted labor amount.
- The non-labor portion is 40% of the APC rate = $244.796.
- The sum of the adjusted labor amount + the non-labor amount = $572.08.
- Therefore, the Medicare facility specific amount = $572.08. This amount is multiplied by 200 percent for a MAR of $1,144.16.

Total MAR:

- The sum of the MAR amounts above = $2,325.38 total MAR for the disputed services rendered on May 15, 2024.

The total recommended reimbursement for the disputed services is $2,325.38. The insurance carrier paid $0.00. Therefore, payment in the amount of $2,325.38 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 requestor has established that reimbursement in the amount of $2,325.38 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 National Interstate Insurance Co. must remit to Hendrick Medical Center $2,325.38 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	April 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, 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.