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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
South Texas Radiology Group

Respondent Name
ACIG Insurance Co

MFDR Tracking Number
M4-13-3391-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
August 9, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We filed our claims to Nova pro Solutions several times before finally received a past filing deadline denial. The first time we submitted our claim was well within the 95 days allowed."

Amount in Dispute: $10.58

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received however no position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 17, 2012	73140	$10.58	$10.58

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 requirements for medical bill submission by health care providers.
3. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
4. 28 Texas Administrative Code §134.203 sets out reimbursement guidelines for professional medical services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 29 – Time limit for filing claim has expired

Issues

1. Did the requestor support that the service in disputed was submitted timely?
2. Is the requestor entitled to reimbursement?

Findings

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on September 4, 2013. The insurance carrier did not submit a response for consideration in this review. Per the Division's former rule at 28 Texas Administrative Code §133.307(d)(1), effective May 25, 2008, 33 *Texas Register* 3954, "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." Accordingly, this decision is based on the available information.
2. The carrier denied the disputed service as 29 – "Time limit for filing claim has expired." 28 Texas Administrative Code §§133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." Review of the submitted documentation finds the original filing dated was January 17, 2013 and the second March 21, 2013. Both of which are within 95 day filing window. The carrier's denial is not supported.
3. Per 28 Texas Administrative Code §134.203(c) "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications." "(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery… "when performed in a facility setting, the established conversion factor to be applied is date of service early conversion factor" or (TDI-DWC Conversion Factor / Medicare Conversion Factor) x facility price = MAR (68.88 / 34.0376) x 6.56 = $13.28.
4. The total MAR is $13.28. The requestor is seeking 10.58. 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 $10.58.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $10.58 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September , 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §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 MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **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.