



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

BRYAN RADIOLOGY ASSOCIATES

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-14-0867-01

Carrier's Austin Representative

Box Number: 54

MFDR Date Received

NOVEMBER 4, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "This claim was filed to patients employer on 05/17/13. We called [REDACTED] on 07/22/13 was given Texas Mutual from Ozzie. The patients employer never forward the claim. We did have proof of filing."

Amount in Dispute: \$41.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 4/11/2013 to 4/112013. 1. BRYAN RADIOLOGY ASSOCIATES INC provided services to the claimant on the date above. 2. BRYAN RADIOLOGY ASSOCIATES INC submitted its bill to the claimant's employer based on information provided by the claimant. 3. BRYAN RADIOLOGY ASSOCIATES INC states it contacted the employer on 7/22/13 and was informed of the relevant carrier. 4. Texas Mutual on 7/25/13 received a bill from BRYAN RADIOLOGY ASSOCIATES INC. (Attachment) 5. Ninety-five dates from 4/11/13 is 7/15/13. 6. Rule 133.20(b) states, '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. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied.' The rational given by the requestor for the late bill is not consistent with the Rule above. No payment is due."

Response Submitted by: TEXAS MUTUAL INSURANCE CO.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 11, 2013	Radiological Services	\$41.00	\$0.00

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

- 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical

fee dispute.

2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 29 – The time limit for filing has expired.
 - 731 – Per 133.20 provider shall not submit a medical bill later than the 95th day after the date the service, for services on or after 9/1/05.
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was process properly.
 - 724 – No additional payment after a reconsideration of services.

Issues

1. Did the requestor bill the employer?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. Review of the documentation submitted by the requestor finds that the employer, American Extrusion, was initially billed.
2. In accordance with 28 Texas Administrative Code 133.20(j) The health care provider may elect to bill the injured employee's employer if the employer has indicated a willingness to pay the medical bill(s). Such billing is subject to the following: (1) A health care provider who elects to submit medical bills to an employer waives, for the duration of the election period, the rights to: (C) medical dispute resolution as provided by Labor Code §413.031. (2)When a health care provider bills the employer, the health care provider shall submit an information copy of the bill to the insurance carrier, which clearly indicates that the information copy is not a request for payment from the insurance carrier. Review of the submitted documentation finds that the requestor submitted the initial bill to the employer; therefore and has waived the right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has waived the right to medical fee dispute resolution. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

November 12, 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.