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**
SOUTH TEXAS RADIOLOGY GROUP

**Respondent Name**
FEDERAL INSURANCE CO

**MFDR Tracking Number**
M4-14-1956-02

**Carrier's Austin Representative**
Box Number 17

**MFDR Date Received**
March 4, 2014

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "We are submitting a corrected claim with a corrected Diagnosis code in accordance with the Contested Case Hearing Decision issued by Texas Department of Insurance Division of Workers Compensation. (see attachment A) Please process our claim for payment. Please consider this when processing our corrected claim."

**Amount in Dispute:** $441.07

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** 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 March 12, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "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. 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." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review."

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| November 14, 2011 and November 17, 2011 | 71020, 70360, 72141, 72146, 70551 and 74230 | $441.07 | $0.00 |

## *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 medical bill submission procedures for health care providers.
3. 28 Texas Administrative Code §102.4 establishes rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
5. Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical claim.

6. The insurance carrier reduced payment for the dispu
7. ted services with the following claim adjustment codes:
   - 29 – The Time limit for filing has expired
   - 18 – Duplicate claim/service
   - W3 – Appeal/Reconsideration

**Issues**

1. What are the disputed issues contained in this dispute?
2. What is the timely filing deadline applicable to the medical bills for the services in dispute?
3. Did the requestor forfeit the right to reimbursement for the services in dispute?
4. Did the requestor waive the right to medical fee dispute resolution?

**Findings**

1. The requestor seeks reimbursement for radiology services rendered on November 14, 2011 and November 17, 2011. The requestor billed the insurance carrier with diagnosis codes, 787.20 and 783.3. The insurance carrier denied the services with denial reason codes, "219 – Based on extent of injury" as indicated on the EOB dated, December 30, 2011. The requestor appealed the insurance carrier's denial and submitted a reconsideration bill. The insurance carrier denied the disputed services with denial reason code "219 – Based on extent of injury", as indicated on the EOB dated, March 19, 2012.

   Review of the submitted documentation supports that the requestor obtained a copy of a CCH decision dated September 20, 2013, found in favor of the injured employee. The requestor subsequently submitted another bill and a reconsideration bill to the insurance carrier with corrected diagnosis codes, 310.2 and 847.0. The insurance carrier audited and denied the services with denial reason codes, "29 – "The Time limit for filing has expired" and 18 – "Duplicate claim/service", and W3 – "Appeal/Reconsideration" as indicated on the EOBs dated, October 21, 2013, October 22, 2013, December 31, 2013 and January 2, 2014.

2. The insurance carrier denied the disputed services with claim adjustment reason codes: 29 – "The Time limit for filing has expired" and 18 – "Duplicate claim/service", and W3 – "Appeal/Reconsideration." 28 Texas Administrative Code §133.20(b) requires 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."

   Texas Labor Code §408.0272(b) states, "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."

   The requestor submitted insufficient documentation to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the health care provider was required to submit the medical bill not later than 95 days after the date the disputed services were provided.

3. Texas Labor Code §408.027(a) states that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states, "Unless the great weight of evidence indicates otherwise, written communications shall 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 via 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 shall be the next previous day which is not a Sunday or legal holiday."

Review of the submitted information finds insufficient documentation to support that a medical bill was submitted within 95 days from the date the services were provided. Consequently, the requestor has forfeited the right to reimbursement due to untimely submission of the medical bill, pursuant to Texas Labor Code §408.027(a).

4. In the alternative, 28 Texas Administrative Code §133.307(c)(1) states, "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute."

   The Requestor submitted sufficient documentation to support that the disputed services, which contained "extent of injury" denials on the EOBs were resolved through Chapter 141 process. As, a result, the dispute does not contain unresolved issues of "extent-of-injury," therefore the disputed services are reviewed pursuant to the applicable Division guidelines.

   The dates of the services in dispute are November 14, 2011 and November 17, 2011. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on March 4, 2014. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. 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, 2015<br>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 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 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**.