



MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

South Texas Radiology Grp

Respondent Name

Farmington Casualty Co

MFDR Tracking Number

M4-16-1101-01

Carrier's Austin Representative

Box Number 05

MFDR Date Received

December 28, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We billed Travelers within 95 days of receiving correct Insurance information."

Amount in Dispute: \$402.77

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Here, the Provider billed a private healthcare administrator, not one of the entities name in subsection (b)(1). As such, the Provider has not demonstrated that they timely billed on the 408.0272 entities to invoke the exception to untimely filing. Consequently, the Provider is not entitled to reimbursement."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 4, 2015	72125 -26, 59 70450 -26, 59 71010 -26 71260 -26 74177 -26	\$402.77	\$402.75

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 §133.2 defines words and terms related to medical billing and processing.
3. 28 Texas Administrative Code §133.210 sets out requirements for medical documentation.
4. 28 Texas Administrative Code §133.20 sets out requirements for medical bill submission by health care

providers.

5. 28 Texas Administrative Code 134.203 sets out the reimbursement guidelines for professional medical services.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 29 – The time limit for filing has expired
 - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment

Issues

1. Is the respondent's position statement supported?
2. Is the carrier's denial supported?
3. What is the applicable rule pertaining to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent states, "Here, the Provider billed a private healthcare administrator, not one of the entities name in subsection (b)(1). As such, the Provider has not demonstrated that they timely billed on the 408.0272 entities to invoke the exception to untimely filing. Consequently, the Provider is not entitled to reimbursement." 28 Texas Administrative Code §133.2 states,

Agent--A person whom a system participant utilizes or contracts with for the purpose of providing claims service or fulfilling medical bill processing obligations under Labor Code, Title 5 and rules. The system participant who utilizes or contracts with the agent may also be responsible for the administrative violations of that agent. This definition does not apply to "agent" as used in the term "pharmacy processing agent."

The Division finds the "private healthcare administrator" meets the above requirements and would therefore be considered an agent of the system participant.

28 Texas Administrative Code §133.210 (e) states,

It is the insurance carrier's obligation to furnish its agents with any documentation necessary for the resolution of a medical bill. The Division considers any medical billing information or documentation possessed by one entity to be simultaneously possessed by the other.

Pursuant to 28 TAC 133.210(e) the respondents' position statement is not supported.

2. 28 Texas Administrative Code §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 medical bill submitted by the health care provider to the correct workers' compensation insurance carrier is subject to the billing, review, and dispute processes established by Chapter 133, including §133.307(c)(2)(A) - (H) of this title (relating to MDR of Fee Disputes), which establishes the generally acceptable standards for documentation.

Review of the submitted documentation finds:

- Claims with signature date March 23, 2015 with submitted codes 70450 -26, 59, 71010 -26, 71260 -26, 74177 -26, 72125 -26, 59 for date of service February 4, 2015. These codes for date of service were submitted to RH Administrators.

- Information from requestor stating on July 14, 2015, "...patient's spouse provided Travelers Worker's Compensation claim information & requested that we submit our claim to Travelers for date of service 2/4/15 as this was work related injury.
- Explanation from Travelers with EOR date August 5, 2015 showing date of bill(s) July 20, 2015, date bill(s) received July 30, 2015.

Therefore, the documentation supports that the requestor submitted a bill to the correct worker's compensation insurance carrier in a timely manner as defined by 28 Texas Administrative Code §133.20 (b).

3. 28 Texas Administrative Code 134.203 (c) states,

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 an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

The services in dispute will be calculated as follows:

Date of Service	Submitted Code	Allowable	MAR (DWC Conversion Factor / Medicare Conversion Factor) x Participating amount = TX FEE MAR
February 4, 2015	72125 -26, 59	\$52.88	$(56.2 / 35.7547) \times \$52.88 = \$83.12$
February 4, 2015	70450 -26, 59	\$42.09	$(56.2 / 35.7547) \times \$42.09 = \$66.16$
February 4, 2015	71010 -26	\$9.03	$(56.2 / 35.7547) \times \$9.03 = \$14.19$
February 4, 2015	71260 -26	\$61.56	$(56.2 / 35.7547) \times \$61.56 = \$96.76$
February 4, 2015	74177 -26	\$90.67	$(56.2 / 35.7547) \times \$90.67 = \$142.52$
	Total		\$402.75

4. The total allowable for the services in dispute is \$402.75. The carrier previously paid \$0.00. The remaining balance of \$402.75 is due to the requestor.

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 \$402.75.

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 \$402.75 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

January 28, 2016
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, 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.