TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name**
SOUTH TEXAS RADIOLOGY GROUP

**Respondent Name**
WC SOLUTIONS

**MFDR Tracking Number**
M4-16-1811-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
MARCH 1, 2016

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "We originally sent our bills to HCC Medical Insurance on 03/19/2015 as this is the information we were provided with. Then on 05/04/2015 we received a denied EOB requesting additional information. Months later we received a phone call from the patient & we were provided with Edwards Claims Workers' Compensation information. Now our claims & request for reconsideration are denied for past filing deadline."

**Amount in Dispute:** $14.10

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Starr Comprehensive Solutions, Inc. maintains the position that the requester is not entitled to reimbursement as complete paper medical bill on the 1500 Health Insurance Claim Form Version 02/12 (CMS-1500) was not submitted within the 95 day deadline."

**Response Submitted by:** Starr Comprehensive Solutions

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| March 11, 2015 | CPT Code 73080-26<br>Professional Component for X-Ray of Elbow | $14.10 | $14.10 |

## *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. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
2. Texas Labor Code §408.0272, effective September 1, 2007, provides for exceptions for timely submission of a claim by a health care provider.
3. The services in dispute were reduced / denied by the respondent with the following reason codes:
   - 29-The time limit for filing claim has expired

- W3-Additional reimbursement made on reconsideration.
- 193-Original payment decision is being maintained. This claim was processed properly the first time.
- W3/193-Per rule 134.804, W3 is to be used when a payment is made following a request for reconsideration. The service adjustment amount associated with this code may be zero. Original payment decision is being maintained.
- 29-The documentation submitted did not provide convincing evidence to support the position that this bill was submitted timely to the Workers' Compensation carrier.
- 29-Per rule 133.20(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.
- 18-Duplicate claim/service.

**Issues**

1. Did the respondent submit the response in accordance with 28 Texas Administrative Code §133.307?
2. Does the disputed bill meet exception for filing timely?
3. Is the requestor entitled to reimbursement?

**Findings**

1. The respondent states in the position summary "Starr Comprehensive Solutions, Inc. maintains the position that the requester is not entitled to reimbursement as complete paper medical bill on the 1500 Health Insurance Claim Form Version 02/12 (CMS-1500) was not submitted within the 95 day deadline."

   28 Texas Administrative Code §133.307(d)(F) states, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section."

   The Division reviewed the submitted documentation and finds that the issue of submitting a complete paper medical bill was not presented to the requestor prior to the date the request for MFDR was filed with the division; therefore, the response was not submitted in accordance with 28 Texas Administrative Code §133.307.

2. Texas Labor Code §408.027(a) states, "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. 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."

   Texas Labor Code §408.0272(b)(1) 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."

   According to the explanation of benefits, the respondent denied reimbursement for the services in dispute based upon reason code "29-The time limit for filing has expired."

   The requestor wrote, "03/19/2015-We initially billed HCC Medical Insurance as this is the information we received." In support of this position the requestor submitted a copy of Connally Memorial Medical Center Admission report that indicates that insurance coverage was provided by HCC Medical Insurance. The requestor also stated "08/17/2015-We received a phone call from the patient. He provided Edwards Claims Worker's Comp information…08/27/2015-We verified the workers comp information and updated our system & mailed our bill to Edwards Claims Administration." In support of this position the requestor submitted copies of explanation of benefits from Starr Comprehensive Solutions, Inc. dated September 13, 2015 for the disputed service.

   The Division finds that the requestor supported position that they meet the exception for 95 day filing deadline per Texas Labor Code §408.0272(b)(1).

3. Per 28 Texas Administrative Code §134.203(c)(1)(2), “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 $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007.”

The 2015 DWC conversion factor for this service 56.2.

The Medicare Conversion Factor is 35.7547.

Review of Box 32 on the CMS-1500 the services were rendered in zip code 78114, which is located in Floresville, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for “Rest of Texas”.

The Medicare Participating Amount is $8.97.

Using the above formula, the Division finds the MAR is $14.10. The respondent paid $0.00. As a result, reimbursement of $14.10 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 $14.10.

## *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 $14.10 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 | 04/07/2016<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 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**.