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 IMAGING

Respondent Name
CHURCH MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-19-5187-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
August 13, 2019

Response Submitted By
No response received from insurance carrier

REQUESTOR'S POSITION SUMMARY

"We initially billed [group health] Insurance plan as this is the information provided to us. Our claim was processed & allowed amount was applied to the patient's deductible. A couple months later we received a call from Church Mutual rep Vicki. Vicki stated date of service… was a work related injury & patient provided incorrect insurance at the time of service. We billed Church Mutual & received a timely filing denial."

RESPONDENT'S POSITION SUMMARY

The insurance carrier did not submit a response for consideration in this dispute.

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
December 13, 2018	Magnetic Resonance Imaging (MRI) Services	$371.36	$371.36

AUTHORITY

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION BILLING ERROR(S).
   - 270 – NO ALLOWANCE HAS BEEN RECOMMENDED FOR THIS PROCEDURE/SERVICE/SUPPLY PLEASE SEE SPECIAL *NOTE* BELOW
     - PER TDI Title 28 Chapter 134.801 providers only have 95 days to submit medical bills for payment from the date of service
   - 350 – BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. Did the insurance carrier respond to the request for medical fee dispute resolution (MFDR)?
2. Are the insurance carrier's reasons for denial of payment supported?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The Austin carrier representative for Church Mutual Insurance Company is Downs Stanford, P.C., who acknowledged receipt of a copy of the MFDR request on August 21, 2019. Rule 28 Texas Administrative Code §133.307(d)(1) provides, if the division does not receive a response within 14 calendar days of dispute notification, the division may base its decision on the available information. To date, no response has been received. Consequently, this decision is based on the information available at the time of review.
2. The insurance carrier denied disputed services with claim adjustment reason codes:
   - 16 – CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION BILLING ERROR(S).
   - 270 – NO ALLOWANCE HAS BEEN RECOMMENDED FOR THIS PROCEDURE/SERVICE/SUPPLY PLEASE SEE SPECIAL *NOTE* BELOW
     - PER TDI Title 28 Chapter 134.801 providers only have 95 days to submit medical bills for payment from the date of service

   The insurance carrier did not state what information was lacking or describe the billing submission errors to which it referred. Review of the submitted information finds no billing errors and the submitted information is sufficient to support the services as billed. The carrier has failed to support denial reason code 16.

   In regard to the bill submission time limit, Rule 28 Texas Administrative Code §133.20(b) requires, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided."

   However, Texas Labor Code §408.0272(b)(1) provides certain exceptions to the 95-day timely filing limit. The provider does not forfeit payment if the provider (within the time limit) submits proof of erroneously billing:

   (A) … 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 …
   (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment…

   Review of the submitted information finds the provider supplied convincing evidence of erroneously billing the injured employee's group health insurer within the 95-day time limit. The provider then submitted the bill to the correct workers' compensation carrier within the time limit allowed following notification of the correct workers' compensation insurance carrier. The provider has therefore met the exception provided in Labor Code §408.0272(b)(1)(A). The insurance carrier's denial reasons are not supported. Accordingly, the disputed services will be reviewed for payment consistent with DWC rules and fee guidelines.
3. This dispute regards MRI services with reimbursement subject to the *Medical Fee Guideline for Professional Services*, 28 Texas Administrative Code §134.203, which determines the maximum allowable reimbursement (MAR) by using Medicare payment policies modified by DWC rules. The MAR is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the DWC annual conversion factor.

   Reimbursement is calculated as follows:

   - Procedure code 73721 has a Work RVU of 1.35 multiplied by the Work GPCI of 1 is 1.35. The practice expense RVU of 5.28 multiplied by the PE GPCI of 0.938 is 4.95264. The malpractice RVU of 0.1 multiplied by the malpractice GPCI of 0.796 is 0.0796. The sum is 6.38224 multiplied by the DWC conversion factor of $58.31 for a MAR of $372.15.

   The total allowable reimbursement for the disputed services is $372.15. The insurance carrier paid $0.00. The requestor is seeking additional reimbursement of $371.36. This amount is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of the division is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above, the requestor has established that payment is due. As a result, the amount ordered is $371.36.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable), based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $371.36, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

______________________	Grayson Richardson	October 18, 2019
Signature	Medical Fee Dispute Resolution Officer	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 TAC §133.307.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). DWC must receive the request within twenty days of your receipt of this decision.

You may fax, mail or personally deliver the request to either the field office handling the claim or to DWC at the contact information on the form. You must send a copy to all other parties in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** along with any other information required by 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.