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
STATE NATIONAL INSURANCE CO

MFDR Tracking Number
M4-20-2705-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JULY 15, 2020

REQUESTOR'S POSITION SUMMARY

"We billed Humana as this is the information provided to us. The claim was rejected due to patient not eligible. Months later we received correspondence from the patient to inform us Humana was provided in error. We were provided with Workers Comp Insurance claim information. We billed 6 charges to CBCS Workers Comp & all denied for timely filing. We mailed requests for reconsideration for all charges & attached proof of timely filing. We received payment for 3 of the 6 charges. The other 3 charges remain denied for timely filing."

Amount in Dispute: $116.62

RESPONDENT'S POSITION SUMMARY

The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 1, 2019	CPT Code 72125-26	$87.81	$87.81
	CPT Code 73030-26-LT	$15.57	$15.57
	CPT Code 73020-26-XU-LT	$13.24	$13.24
TOTAL		$116.62	$116.62

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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective May 31, 2012, sets out the procedures for resolving

medical fee disputes.

2. Texas Labor Code (TLC) §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
3. TLC §408.0272, effective September 1, 2007, provides for exceptions for timely submission of a claim by a health care provider.
4. 28 TAC §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
5. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
6. The services in dispute were reduced / denied by the respondent with the following reason codes:
   - 29-The time limit for filing has expired.
   - 4271-Per TX Labor Code Sec. 413.016, providers must submit bills to payors within 95 days of the date of service.
   - W3-Additional payment made on appeal/reconsideration.
   - 298-The recommended allowance is based on the value for the professional component of the service performed.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 1001-Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
   - 4063-Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting.

Issues

Is the requestor entitled to reimbursement for radiology services rendered on September 1, 2019?

Findings

1. The Austin carrier representative for State National Insurance Co. is Flahive, Ogden & Latson. Flahive, Ogden & Latson received a copy of this medical fee dispute on July 21, 2020. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information

   As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

2. The requestor is seeking medical fee dispute resolution in the amount of $116.62 for CPT codes 72125-26, 73030-26-LT, and 73020-26-XU-LT rendered on September 1, 2019.

3. The respondent denied reimbursement for the disputed services based upon "29-The time limit for filing has expired."

4. To determine if the disputed services are eligible for reimbursement the DWC refers to the following statute:

   - TLC §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."

   - TLC §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."

   - 28 TAC §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."

- 28 TAC §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."

5. The DWC reviewed all the submitted documentation and finds:

- The date of service in dispute is September 1, 2019.
- The requestor initially billed Humana for the disputed services.
- On December 30, 2019, the claimant notified the requestor that this claim should have been billed to CBCS.
- The requestor supported position that they meet exception for timely filing outlined in TLC §408.0272(b)(1)(A) because billed the claimant's private insurance.
- Based upon the EOB, the respondent received the bill for the disputed services on February 10, 2020. This date is within the 95 day deadline to bill the correct carrier upon notification of the provider's erroneous submission of bill.
- The requestor supported position that reimbursement is due.

6. The fee guidelines for disputed services is found at 28 TAC §134.203.

- 28 TAC §134.203(a)(5) states, "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

- 28 TAC 134.203(b)(1) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

7. Per 28 TAC §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 DWC had been using this MEI annual percentage adjustment: The 2006 DWC 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) DWC conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

The 2019 DWC conversion factor for this service is 59.19.

The Medicare Conversion Factor is 36.0391

Review of Box 32 on the CMS-1500 the services were rendered in Jourdanton, Texas; therefore, the locality will be based on the rate for "Rest of Texas".

The requestor billed for the services with modifier 26-Professional component.

Using the above formula, the DWC finds:

Code	Medicare Participating amount	MAR	Insurance Carrier Paid	Amount Due
72125-26	$53.47	$87.81	$0.00	$87.81
73030-26	$9.48	$15.57	$0.00	$15.57
73020-26	$8.06	$13.24	$0.00	$13.24

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $116.62.

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 $116.62 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	09/11/2020 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **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.