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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDING AND DECISION

GENERAL INFORMATION

Requestor Name
SOUTH TEXAS RADIOLOGY GROUP

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-20-2713-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
JULY 15, 2020

REQUESTOR'S POSITION SUMMARY

"We are submitting a corrected claim with the rendering and referring provider's state license #s in the correct boxes on the CMS 1500. Please consider this when processing our corrected claim."

Disputed Amount: $28.25

RESPONDENT'S POSITION SUMMARY

"The Office reviewed the claim file and found that the Office's first receipt of this bill was received on 2/11/20 where the bill was returned to the provider as the bill was deemed incomplete pursuant to Rule §133.10 as Box 24j and Box 17a was not completed…The Office received a complete bill pursuant to Rule §133.20(g) on 4/13/20 where an audit was performed, and charges were denied for 29-Time limit for filing has expired as it was received on 146th day from the date of service."

Response Submitted By: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 18, 2019	CPT Code 73110-26-RT	$14.42	$0.00
	CPT Code 73120-26-RT	$13.83	$0.00
TOTAL		$28.25	$0.00

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 §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.

3. 28 TAC §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
4. 28 TAC §133.20, effective January 29, 2009, sets out the health care providers billing procedures.
5. 28 TAC §133.10, effective April 1, 2014, sets out the required billing forms/formats.
6. 28 TAC §133.240, effective March 30,2014, sets out the medical bill process for payment and denials.
7. 28 TAC §133.250, effective March 30,2014, sets out the reconsideration of payment of medical bill process
8. The services in dispute were reduced / denied by the respondent with the following reason codes:
   - 29-The time limit for filing has expired.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is the respondent's denial of payment based upon timely filing supported?
2. Is the requestor entitled to reimbursement for services rendered on November 18, 2019?

Findings

1. The requestor is seeking payment of $28.25 for CPT codes 73110-26-RT and 73120-26-RT rendered on November 18, 2019.

2. The respondent wrote, "The Office received a complete bill pursuant to Rule §133.20(g) on 4/13/20 where an audit was performed, and charges were denied for 29-Time limit for filing has expired as it was received on 146th day from the date of service."

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

   - 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."

   - 28 TAC §133.10(f)(1)(R) states, "All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form. (1) The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care: (R) diagnosis pointer (CMS-1500, field 24E) is required."

   - 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 §133.20(g) states, "Health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier."

   - 28 TAC §133.240(a) states, "An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation."

   - Per the Texas Register Preamble, "Section 133.250(d)(1). Comment: Commenters recommend subsection 133.250(d)(1) be amended to require modifiers and number of units in addition to the original billing codes.

Agency Response: The Division declines to make the requested change. A reconsideration request may include corrections relating to modifiers and/or number of units. For this reason, a request for reconsideration may include changes in the number of units or modifiers from that in the original bill for proper processing and payment of the bill."

4. Both parties to this dispute submitted documentation for consideration in support of their position. The DWC reviewed all the documentation and finds:

- The date of service in dispute is November 18, 2019.
- The requestor initially billed the respondent on February 6, 2019.
- The respondent wrote the requestor that the bill was incomplete and missing required information.
- On April 6, 2020, the requestor submitted a corrected bill.
- The Preamble clarified that only modifiers and number of units may be amended from the original bill.
- Per 28 TAC §133.20(g) the corrected bill is a new bill.
- The requestor did not support that the claim was submitted to the respondent within the 95 day deadline set out in Texas Labor Code §408.027(a) and 28 TAC §133.20(b).
- The respondent's denial of payment based upon timely filing is supported.
- The requestor is not due reimbursement for CPT codes 73110-26-RT and 73120-26-RT.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that 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 DWC has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	08/12/2020 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.