TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
South Texas Radiology

Respondent Name
Bradford Holding Company Inc

MFDR Tracking Number M4-23-0893-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
December 19, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 23, 2021	93970	$335.65	$0.00
	Total	$335.65	$0.00

Requestor's Position

"We billed Humana insurance as this is the information the patient provided. We received a refund request from Humana stating date of service 12/23/21 was related to a work related injury. We billed Johnston & Associates & our bill was denied for past timely filing deadline. We mailed & faxed in our request for reconsideration with proof of timely filing & we have not received a response to our request. Please help us with final adjudication of this bill for date of service 12/23/2021."

Amount in Dispute: $335.65

Respondent's Position

The Austin carrier representative for Bradford Holding Company is Down Stanford. The representative was notified of this medical fee dispute on December 28, 2022.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available

information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

Findings and Decision

Authority

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

Statutes and Rules

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.20 sets out requirements of medical bill submission.

3. Texas Labor Code 408.0272 sets out the workers compensation timely billing and exceptions guidelines.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 206 – (No narrative found on submitted explanation of benefits)

Issues

1. Did the requestor support timely submission of medical claim?

Findings

1. The requestor is seeking reimbursement for a radiology service rendered in December 2021. The requestor indicates the claim was denied as past timely filing and "We billed Humana insurance as this is the insurance provided by the patient. … 05/16/2022 Humana recouped their payment. 07/05/2022 We faxed in our bill to Johnston & Associates Worker' Compensation claims processing."

   DWC Rule 28 TAC §133.20 (b) states in pertinent part,

   (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. In accordance with subsection (c) of the statue, 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.

Texas Labor Code §408.0272. (b) states in pertinent part,

(b) Notwithstanding Section §408.0272, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section §408.0272(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 408.0272 (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;

(2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

Review of the submitted documentation did not find sufficient documentation to support the reported date of notification of the erroneous bill.

Insufficient evidence was found to support the exception for submission after erroneous claim submission was found as outlined in DWC Rule TAC §133.20 (b).

No payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services.

Authorized Signature

		May 11, 2023
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.