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

General Information

Requestor Name
South Texas Radiology Group

Respondent Name
Zurich American Insurance Co.

MFDR Tracking Number
M4-25-1052-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
January 17, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 9, 2024	73701-26-LT	$138.75	$108.74

Requestor's Position

"We billed Paradigm as this is the information we received. Paradigm sent us an EOB stating they no longer handle this claim & forwarded our bill to the correct carrier. We called Paradigm to get the new carrier information. We were informed Creative Risk Solutions is the new Carrier. We mailed our bill to Creative Risk. Our bill was denied for timely filing. We mailed a request for reconsideration with proof of timely filing on 10/24/24. I called for status of the appeal & I was told no reconsideration on file. I resent the appeal & as of today no response to our request for reconsideration."

Amount in Dispute: $138.75

Respondent's Position

The Austin carrier representative for Zurich American Insurance Co. is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on January 23, 2025.

Per 28 Texas Administrative Code §133.307(d)(1), if DWC does not receive the response within 14 calendar days of the dispute notification, then 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 (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

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

2. 28 TAC §134.203 sets out the fee guidelines for professional services.

3. TLC §408.027 sets out the requirements for payment of health care providers.

4. TLC §408.0272 sets out the exceptions for the untimely filing of a medical bill.

Denial Reasons

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

Paradigm:

- P12-1 – Workers' compensation jurisdictional fee schedule adjustment.
- 755 – These services fall outside the existing paradigm contract. We have forwarded these charges to the correct carrier.
- 109 – Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.

Medata:

- 1H (P12) – The service has been rendered in an area which meets the definition of a Health Professional Shortage Area (HPSA).
- NZ (P12) – A charge for the interpretation of a diagnostic procedure (modifier 26 and or 76140 for radiology) has already been paid or is included in the examination services rendered on this date.
- XD (P12) – This bill was submitted after the billing timelines guidelines provided.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Is Zurich American Insurance Co.'s denial based on timely filing supported?

2. Is Zurich American Insurance Co.'s denial based on prior payment supported?

3. Is South Texas Radiology Group entitled to reimbursement for the service in question?

Findings

1. South Texas Radiology Group is seeking reimbursement for procedure code 73701-26-LT performed on date of service May 9, 2024. The insurance carrier denied the service, in part, stating, "This bill was submitted after the billing timelines guidelines provided."

   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."

   The greater weight of evidence provided to DWC indicates that the requestor submitted a medical bill to Paradigm Medical Bill Review Department (Paradigm) on or about May 22, 2024, which was received by Paradigm on May 28, 2024. This date is less than 95 days after the date of service.

   The documentation included an explanation of benefits dated July 3, 2024, that was received by South Texas Radiology Group on or about July 17, 2024.

   The greater weight of evidence provided to DWC indicates that the requestor submitted a medical bill to Creative Risk Solutions on or about August 21, 2024, which was received by Medata Service Bureau (Medata) on August 28, 2024. The evidence indicates that Medata is an agent of Zurich American Insurance Co. This date is more than 95 days after the date of service.

   TLC §408.0272 states, in relevant part,

   > (b) 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: …
   >
   > (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title …

(c) Notwithstanding Subsection (b), a health care provider who erroneously submits a claim for payment to an entity described by Subdivision (1) of that subsection forfeits the provider's right to reimbursement for that claim if the provider fails to submit the claim to the correct workers' compensation insurance carrier within 95 days after the date the provider is notified of the provider's erroneous submission of the claim.

DWC finds that the reported date of submission of the medical bill in question to the correct workers' compensation insurance carrier was less than 95 days after the date it was notified of its erroneous submission of the claim to Paradigm. The greater weight of evidence supports the requestor's claim that the medical bill for the service in question was submitted timely. The insurance carrier provided no evidence to support a denial based on timely filing.

2. The service in question, procedure code 73701 is defined as, "Computed tomography, lower extremity; with contrast material(s)." Modifier 26 indicates the professional component, and modifier LT indicates the left side. The insurance carrier denied payment for this service, in part, stating, "A charge for the interpretation of a diagnostic procedure (modifier 26 and or 76140 for radiology) has already been paid or is included in the examination services rendered on this date."

   No evidence was provided to support a prior payment or inclusion in examination services for the service on the date in question. DWC finds that denial of payment for this reason is not supported.

3. Because the insurance carrier failed to support its denial of payment for the service in question, DWC finds that South Texas Radiology Group is entitled to reimbursement.

   Reimbursement policies for professional services is found in 28 TAC §134.203, which states, in relevant part: "(b) 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."

   Reimbursement fee guidelines for professional services are addressed in 28 TAC §134.203(c), which states in relevant part: "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 …

(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 …"

To determine the maximum allowable reimbursement (MAR), the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) x Medicare Participating Amount.

- The DWC conversion factor for 2024 is 67.81.
- The Medicare conversion factor for May 9, 2024, is 33.2875.
- Per the submitted medical bills, the service was rendered in zip code 78840 which is in Medicare locality 441299.
- The Medicare participating amount for CPT code 73701-26-LT is $53.38.

The MAR is calculated as follows: (67.81/33.2875) x $53.38 = $108.74. This amount 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 requestor has established that reimbursement of $108.74 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that Zurich American Insurance Co. must remit to South Texas Radiology Group $108.74 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 10, 2025 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 three 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 tres o correo electronico CompConnection@tdi.texas.gov.