



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

South Texas Radiology

Respondent Name

Travelers Casualty & Surety Co

MFDR Tracking Number

M4-25-2002-01

Carrier's Austin Representative

Box Number 05

DWC Date Received

April 25, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 16, 2024	20611	\$202.75	\$195.58
August 16, 2024	73700	\$269.88	\$258.73
Total		\$472.63	\$454.31

Requestor's Position

"We billed Humana as this is the information the patient provided. We received a call from the patient & he informed us he provided his Humana insurance care in error & date of service 08/16/2024 was related to work injury. He provided Travelers. We billed Travelers & our bill was denied for past filing deadline. We mailed in our request for reconsideration with proof of timely filing. The requests for reconsideration were denied by the adjuster."

Amount in Dispute: \$472.63

Respondent's Position

"First, the Provider has previously billed the Carrier for services related to this claim. The Provider submitted billing to the Carrier and was reimbursed in September of 2014, May of 2015 and October of 2021. Furthermore, the Provider contacted the Carrier by phone on 0[sic] -16-2024, the date of service to confirm the scope of the preauthorization approval they had received. Based on the totality of the circumstances, the Provider was well aware of the proper carrier to bill and simply failed to do so..."

Response Submitted by: Travelers

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 §133.20](#) sets out requirements of medical bill submission.
3. [28 TAC §102.4](#) details the general rules for Non-Division Communication.
4. [Texas Labor Code 408.0272](#) sets out the workers compensation timely billing and exceptions guidelines.
5. [28 TAC §134.203](#) sets out the fee guidelines for professional medical services.

Denial Reasons

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

- 29 – The time limit for filing has expired.
- 4271 – Per TX Labor Code sec. 408.027, providers must submit bills to payors within 95 days of the date of service.
- W3 – Bill is a reconsideration or appeal

Issues

1. Did the requestor support the original claim submission to an insurance carrier other than the worker's compensation carrier responsible for the claim?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to payment?

Findings

1. The requestor is seeking reimbursement of professional medical services rendered in August of 2024. The insurance carrier denied the services as not being submitted timely. The requestor states a claim was submitted to the correct worker's compensation carrier after notification of the workers' compensation coverage.

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.

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 408.027(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;

Review of the information submitted for the disputed date of service August 16, 2024 includes the following.

- Copy of medical bill for 73700 RT for DOS 8-16-24. Submitted to Humana Medicare.
- Copy of medical bill for 20611 for DOS 8-16-24 submitted to Humana Medicare.
- Humana explanation of benefits dated August 31, 2024 indicates payment of code 20611.
- Humana explanation of benefits dated September 3, 2024 indicates payment of code 73700 RT.
- Request for reconsideration indicates, 10/25/24, "We received a call from the patient & he advised incorrect insurance was provided. He then provided Travelers & asked us to bill Travelers for DOS 8/16/24 as this was related to a work injury."
- Travelers explanation of benefits indicated bill was received December 2, 2024.

DWC finds the greater weight of evidence supports the requestor erroneously filed for reimbursement with health insurance other than the workers' compensation carrier responsible for the claim. While the insurance carrier made statements regarding the requestor knowledge that Travelers was the worker's compensation carrier, the information submitted was related to past dates of service and was not considered in this review.

2. DWC Rule 28 Texas Administrative Code §134.203(c)(1) states, "...To determine to MAR for professional services, system participants shall apply the Medicare payment policies with minimal modification...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 \$53.68..."

The following formula represents the calculation of the DWC MAR at §134.203 (c)(1) & (2).

(DWC Conversion Factor ÷ Medicare Conversion Factor) x Medicare Payment = MAR. In this instance,

- $67.81/33.2875 \times \$96.01$ for code 20611 (for location San Antonio, Texas) = \$195.58.
- $67.81/33.2875 \times \$127.01$ for code 73700 (for location San Antonio, Texas) = \$258.73

3. The total allowable DWC fee guideline reimbursement is \$454.31. 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 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 Travelers Casualty & Surety Co must remit to South Texas Radiology Imaging \$454.31 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

June 5, 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 electrónico CompConnection@tdi.texas.gov.