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
KINETIC CLINIC

Respondent Name
AMERICAN HOME ASSURANCE CO

MFDR Tracking Number
M4-12-2833-02

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 4, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please process our bills accordingly and send payment to: Medical billing dept...."

Amount in Dispute: $540.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on May 8, 2012. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
April 18, 2011 through July 12, 2011	99214 x 4, 99080-73 x 4	$540.00	$0.00

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.

Background

1. 28 Texas Administrative Code §133.305 sets out the general Medical Dispute Resolution guidelines.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedure for Medical Dispute Resolution of Medical Necessity Disputes.
4. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
5. 28 Texas Administrative Code §102.4 establishes rules for non-Commission communications.
6. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
7. Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical claim.
8. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 216 – Based on the findings of a review organization
   - W9 – Unnecessary medical treatment based on peer review. Services denied.
   - 214 – Workers Compensation claim adjudicated as non-compensable. This payer not liable for claim or service/treatment. Services denied.
   - 29 – The time limit for filing has expired

Issues

1. What is the timely filing deadline applicable to dates of service May 17, 2011 and June 14, 2011?
2. What are the denial reason(s) raised by the insurance carrier during the bill review process?
3. Does the dispute contain documentation to support that there are **unresolved** issues of medical necessity for date of service, July 12, 2011?
4. Does the dispute contain documentation to support that there are unresolved issues of Liability for dates of service April 18, 2011 and July 12, 2011?
5. Are the disputed services eligible for review by Medical Fee Dispute Resolution?

Findings

1. The insurance carrier denied the disputed dates of service May 17, 2011 and June 14, 2011 with claim adjustment reason codes: 29 – "THE TIME LIMIT FOR FILING HAS EXPIRED. 28 Texas Administrative Code §133.20(b) requires that, except as provided in Texas Labor Code §408.0272, "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) provides that:

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

   Texas Labor Code §408.027(a) states that "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 Texas Administrative Code §102.4(h) states that:

   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.

   The requestor submitted insufficient documentation to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the disputed services rendered on May 17, 2011 and June 14, 2011. For that reason, the health care provider was required to submit the medical bill for dates of service May 17, 2011 and June 14, 2011 not later than 95 days after the date the disputed services were provided. Consequently, the requestor has forfeited the right to reimbursement due to untimely submission of the medical bill for dates of service May 17, 2011 and June 14, 2011, pursuant to Texas Labor Code §408.027(a).

2. The medical fee dispute referenced above contains information/documentation to indicate that there are **unresolved** issues of medical necessity and liability for the same service(s) for which there is a medical fee dispute. Review of the EOBs presented by the requestor indicate denial reason codes "216 – Based on the findings of a review organization," "W9 – Unnecessary medical treatment based on peer review. Services denied" and "214 – Workers Compensation claim adjudicated as non-compensable. This payer not liable for claim or service/treatment. Services denied."

3. The medical fee dispute referenced above for date of service July 12, 2011, contains information/documentation that indicates that there are **unresolved** issues of medical necessity for the same service(s) for which there is a medical fee dispute. Review of the EOBs presented by the both the requestor and respondent indicate denial reason code "216 – Based on the findings of a review organization," "W9 – Unnecessary medical treatment based on peer review."

   Review of the submitted documentation finds that the medical fee dispute referenced above contains information/documentation that indicates that there are **unresolved** issues of medical necessity for the same service(s) for which there is a medical fee dispute.

The Division hereby notifies the requestor the appropriate process for resolution of an unresolved issue of medical necessity requires filing for an independent review to be conducted by an IRO (independent review organization) appropriately licensed by the Texas Department of Insurance, pursuant to 28 Texas Administrative Code §133.308. Information applicable to HEALTH CARE PROVIDERS on how to file for an IRO may be found at http://www.tdi.texas.gov/hmo/iro_requests.html under ***Health Care Providers or their authorized representatives.***

28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding…medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding…medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021.

The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals.

The division finds that due to the unresolved medical necessity issues for date of service July 12, 2011 is not eligible for review until a final decision has been issued in accordance with 28 Texas Administrative Code §133.308.

4. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021."

   28 Texas Administrative Code §133.307(e)(3)(H) requires that if the carrier has raised a dispute pertaining to compensability, extent of injury, or liability for the claim, the Division shall notify the parties of the review requirements pursuant to §124.2 of this title, and will dismiss the request until those disputes have been resolved by a final decision, inclusive of all appeals. The appropriate dispute process for unresolved issues of compensability, extent and/or liability requires filing for a Benefit Review Conference pursuant to 28 Texas Administrative Code §141.1 prior to requesting medical fee dispute resolution.

   Review of the submitted documentation finds that there are unresolved issues of liability for dates of service April 18, 2011 and July 12, 2011. No documentation was submitted to support that the issue(s) of liability have been resolved prior to the filing of the request for medical fee dispute resolution.

5. The requestor has failed to support that the disputed services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. This dismissal is based upon a review of all the evidence presented by the parties in this dispute. Even though not all the evidence was discussed, it was considered. The Division finds that this dispute is not eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307.

FINDINGS

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the dispute is not eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 13, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin Texas, 78744. The party seeking review of the MFDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of this *Medical Fee Dispute Resolution Findings and Decision***, together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.