



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 FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

ORTHOPAEDIC ASSOCIATES OF CENTRAL TEXAS

Respondent Name

TRAVIS COUNTY

MFDR Tracking Number

M4-15-1069-01

Carrier's Austin Representative

Box Number: 38

MFDR Date Received

DECEMBER 4, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Request for Reconsideration: "Please review the following claim that was not found in your system. We previously submitted this Request for Reconsideration on 7-24-14 and have included the fax confirmation sheet to prove that this was successfully transmitted."

Amount in Dispute: \$319.71

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This bill was originally audited under review number 4883349 and denied for extent of injury (CARC code 219) allowing \$0 payment. PLN-11 dated 09/06/2012 states injury that was received while in the course and scope of employment is limited to left shoulder strain and left rotator cuff tear only. Provider's bill for DOS 5-13-14 billed with DX 726.2 (Should region dis nec) and DX 726.12 (bicipital tenosynovitis). The bill was finalized on 06/18/2014. Orthopedic Associates of Central Texas billed a Corrected Claim on 7/16/2014. This bill was not billed as a correct reconsideration per Rule 133.250. The corrected bill was received by the carrier on 09/30/2014 with a corrected DX code of 719.41 (joint pain-shoulder). The bill was received by Forte on 09/30/2014. This corrected claim was audited under review number 5276881 and denied for untimely filing allowing \$0 payment. The bill was finalized on 10/15/2014. In review of bills that were submitted on 07/16/2014 for a request for reconsideration, Forte found that the provider changed their diagnosis code to reflect the compensable injury thus making this a 'new' bill as a billing code had been changed. An audit was performed and the bill was denied for timely filing. Literature obtained from the Division..., titled Invalid vs. Valid Billing Codes, the Division explains in this article 'Correct billing codes must be active, valid billing codes on the date of service is performed, such as those codes contained in the current American Medical Association (AMA) editions of the current procedural terminology (CPT), health care common procedure coding system (HCPCS), and *international classification of diseases (ICD) ICD-9 guides*. The entire article references the ICD-9 codes a being a billing code, therefore in this specific case the resubmission of the requestor's bill as a request for reconsideration did not meet the criteria set forth in Rule 133.250..."

Response Submitted By: FORTE

SUMMARY OF FINDINGS

Date of Service	Disputed Services	Amount In Dispute	Amount Due
May 13, 2014	Professional Services	\$319.71	\$182.57

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.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §129.5 sets out the guidelines for Work Status Reports.
4. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
5. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
6. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 219 – Based on Extent of Injury.
 - 29 – The time limit for filing has expired.

Issues

1. Was the extent of injury denial upheld on the reconsideration EOB?
2. Is the timely filing deadline applicable to the medical bills for the services in dispute?
3. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. The initial EOB denied the services in dispute using denial code 219 –“Based on extent of injury.” The insurance carrier did not maintain this denial during the reconsideration process and denied the services using denial code 29 – The time limit for filing has expired.” Therefore, the dispute will be reviewed in accordance with 28 Texas Administrative Code §133.20(b).
2. 28 Texas Administrative Code §133.20(b) states, in pertinent part, 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. 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...” Review of the documentation submitted by the requestor finds that the medical bill was sent to respondent in a timely manner. Therefore, convincing documentation was found to support that the bill was submitted timely.
3. Texas Labor Code §408.027(a) states, in pertinent part, 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.” Review of the submitted information finds documentation, in the form of a fax confirmation sheet, to support that a medical bill was submitted within 95 days from the date the services were provided. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute has not forfeited the right to reimbursement due to untimely submission of the medical bill for the services in dispute.
4. In accordance with 28 Texas Administrative Code §134.204(b)(1) and (c)(1) and 28 Texas Administrative Code §129.5(i) reimbursement is as follows:
 - CPT Code 99214: $(55.75 \div 35.8228) \times \$107.67 = \$167.56$
 - CPT Code 99080-73: \$15.00

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$182.57.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$182.57 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 11, 2015 Date
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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 Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division 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 Division. **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.