



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

UT Southwestern - MSP

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-15-2868-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

May 4, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "... the attached claims were previously filed to the patient's medical insurance plan ... On December 08, 2014, the patient called our customer service department and advised us that these charges should have been filed to workers compensation ... Therefore, we are requesting payment for the attached claims."

Amount in Dispute: \$1802.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "... Texas Mutual on 12/17/14 received the bill from THE UNIVERSITY OF TEXAS SOUTHWESTERN MED for dates 4/29/14, 6/10/14, 7/2/14, 7/15/14, 7/29/14, and 9/4/14... All six bills are past 95 days.

... Texas Mutual on 2/20/15 received the bill from THE UNIVERSITY OF TEXAS SOUTHWESTERN MED for date 11/11/14... This bill is past 95 days...

The rationale given by the requestor for the late bill is not consistent with [Rule 133.20(b)]. No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: April 29 - November 11, 2014; Evaluation & Management, established patient (99213 & 99214); \$1802.00; \$494.88

FINDINGS AND DECISION

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

Background

- 1. 28 Texas Administrative Code §133.305 sets out the general procedures for Medical Dispute Resolution.

2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.20 sets out the procedures for medical bill submission by a health care provider.
4. 28 Texas Administrative Code §133.210 defines the documentation required for medical bills.
5. 28 Texas Administrative Code §102.4 establishes rules for non-Commission communications.
6. 28 Texas Administrative Code §134.203 sets out the guidelines for billing and reimbursing professional medical services.
7. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
8. Texas Labor Code §408.0272 sets out certain exceptions for untimely submission of a claim.
9. Texas Insurance Code §1305.006 defines liability of insurance carriers for out-of-network health care when a claim is part of a certified workers' compensation network.
10. Texas Insurance Code §1305.153 sets out the procedures for provider reimbursement.
11. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - CAC-29 – The time limit for filing has expired.
 - 731 – Per 133.20(b) provider shall not submit a medical bill later than the 95th day after the date the service.
 - CAC-P12 – Workers' Compensation jurisdictional fee schedule adjustment.
 - CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
 - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - 724 – No additional payment after a reconsideration of services.
 - 725 – Approved non-network provider for Texas Star Network Claimant per Rule 1305.153(C).
 - 876 – Required documentation missing or illegible. See rules 133.1; 133.210; 129.5; or 180.22.

Issues

1. Does a network issue exist for this dispute?
2. Did the requestor waive the right to medical fee dispute resolution for any of the disputed services?
3. What is the timely filing deadline applicable to the medical bills for the services in dispute?
4. Did the requestor forfeit the right to reimbursement for the services in dispute?
5. Is the insurance carrier's denial for missing documentation supported for the services in dispute?
6. What is the Maximum Allowable Reimbursement (MAR) for the payable services?
7. Is the requestor entitled to reimbursement?

Findings

1. Texas Insurance Code §1305.006 states, "An insurance carrier that establishes or contracts with a network is liable for the following out-of-network health care that is provided to an injured employee: ... (3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103."

On the Explanation of Benefits dated February 2, 2015, the insurance carrier used claim adjustment reason code "725 – Approved non-network provider for Texas Star Network Claimant per Rule 1305.153(C)." Texas Insurance Code §1305.153 (c) states, "Out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation." Therefore, the Division determines that no network issue exists for this dispute. Consequently, this dispute will be reviewed in accordance with 28 Texas Administrative Codes §§133.305 and 133.307.

2. 28 Texas Administrative Code §133.307(c)(1) states:

Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.

(A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

The services in dispute include date of service April 29, 2014. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on May 4, 2015. This date is later than one year after the specified date of service in dispute. Review of the submitted documentation finds that the disputed service for this date do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file the dispute for date of service April 29, 2014 with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for this date of service. This date of service will not be considered further.

3. The insurance carrier denied disputed services with claim adjustment reason codes "CAC-29 – The time limit for filing has expired," and "731 – Per 133.20(b) provider shall not submit a medical bill later than the 95th day after the date the service." 28 Texas Administrative Code §133.20 (b) requires that

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 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. The medical bill submitted by the health care provider to the correct workers' compensation insurance carrier is subject to the billing, review, and dispute processes established by Chapter 133, including §133.307(c)(2)(A) - (H) of this title (relating to MDR of Fee Disputes), which establishes the generally acceptable standards for documentation.

Texas Labor Code §408.0272 (b) states,

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.

Review of the submitted information finds that the preponderance of evidence supports that the requestor erroneously submitted a timely claim for reimbursement with an insurer under which the injured employee is covered for dates of service June 10, 2014, July 15, 2014, July 29, 2014, August 14, 2014, and September 4, 2014. Therefore, the filing deadline for these dates of service is 95 days from the date that the provider was notified of the health care provider's erroneous submission of the medical bill.

Submitted documentation does not find evidence of erroneous submission with another insurer for date of service November 11, 2014. For that reason, the health care provider was required to submit this medical bill not later than 95 days after the date the disputed services were provided.

4. 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.

Documentation supports that the requestor was notified of erroneous submission of medical bills for the claimant on December 8, 2014. Documentation further supports that the requestor filed dates of service with the correct workers' compensation insurance carrier for dates of service June 10, 2014, July 15, 2014, July 29, 2014, August 14, 2014, and September 4, 2014 on December 8, 2014. The insurance carrier confirms receipt on December 17, 2014 in their position statement. This submission is within 95 days from the date the provider was notified of the health care provider's erroneous submission of the medical bill. Therefore, the requestor has not forfeited the right to reimbursement due to untimely submission of the medical bill, pursuant to Texas Labor Code §408.027(a) for these dates of service.

Regarding date of service November 11, 2014, review of the submitted information finds no documentation to support that a medical bill was submitted within 95 days from the date the services were provided. Consequently, the requestor has forfeited the right to reimbursement due to untimely submission of the medical bill, pursuant to Texas Labor Code §408.027(a). This date of service will not be considered further.

5. The insurance carrier denied the disputed charges for dates of service June 10, 2014, July 15, 2014, July 29, 2014, August 14, 2014, and September 4, 2014 with claim adjustment code "876 – Required documentation missing or illegible. See rules 133.1; 133.210; 129.5; or 180.22." 28 Texas Administrative Code §133.210 (c) states, "In addition to the documentation requirements of subsection (b) of this section, medical bills for the following services shall include the following supporting documentation: (1) the two highest Evaluation and Management office visit codes for new and established patients: office visit notes/report satisfying the American Medical Association requirements for use of those CPT codes."

The disputed services are regarding CPT Code 99214. As one of the two highest Evaluation and Management office visit codes for established patients, this code requires office visit notes for documentation. Review of the submitted documentation found office visit notes that included dates of service June 10, 2014, July 15, 2014, July 29, 2014, and September 4, 2014. The insurance carrier's denial for these dates of service is not supported. They will be reviewed in accordance with applicable fee guidelines.

Office notes were not found for date of service August 14, 2014. Therefore, the insurance carrier's denial for this date of service is supported.

6. Procedure code 99214 for dates of service June 10, 2014, July 15, 2014, July 29, 2014, and September 4, 2014 is a professional service subject to the medical fee guidelines found in 28 Texas Administrative Code §134.203. These guidelines state,
 - (b) 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.
 - (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.

The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. The conversion factor for 2014 is \$55.75. For this procedure, the relative value (RVU) for work of 1.5 multiplied by the geographic practice cost index (GPCI) for work of 1.014 is 1.521. The facility practice expense (PE) RVU of 0.61 multiplied by the PE GPCI of 1.013 is 0.61793. The malpractice RVU of 0.1 multiplied by the malpractice GPCI of 0.803 is 0.0803. The sum of 2.21923 is multiplied by the Division conversion factor of \$55.75 for a MAR of \$123.72 for each date of service.

7. The total MAR for the payable services in dispute is \$494.88. The insurance carrier paid \$0.00. An additional reimbursement of \$494.88 is therefore recommended.

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 \$494.88.

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 \$494.88 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	July 15, 2015
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 in accordance with 28 Texas Administrative Code §133.307, 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 MFDR 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.