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
COURTNEY WALLS DC

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-15-2882-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
MAY 5, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to Texas Mutual on 1-8-15, this request was in response to a $865.00 no pay of the $865.00 for the DDE performed on 6/26-14. Unfortunately our request was denied and we are seeking the balance owed to us. The denial reason(s) per EOB are: Workers Compensation fe schedule adjustment. Designated Doctor Exams are billed according to DWC rule 134.204 and in accordance with labor code 408.004, 408.0041, and 408.151."

Amount in Dispute: $865.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 6/26/14 1. The requestor alleges it submitted the bill, the DWC69, and narrative report to Texas Mutual on 7/16/14. (See p 9.) Texas Mutual searched its claim file for the documentation on or around 7/16/14 and found no such documents. 2. The requestor provided a fax confirmation sheet of the second submission of the same documents that Texas Mutual received on 1/18/15. Texas Mutual did find these documents in its claim with a received date of 1/8/15. 3. However, the requestor did not submit a fax confirmation sheet of the alleged first submission of 7/16/14. Absent such, Texas Mutual is not convinced the billing was timely submitted through the alleged fax of 7/16/14. No payment is due."

Response Submitted by: TEXAS MUTUAL INSURANCE CO.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 16. 2014	DDE Exam Work Status Report	$865.00	$865.00

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 §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
3. 28 Texas Administrative Code §102.4 establishes rules for non-Commission communications.
4. 28 Texas Administrative Code §134.204 establishes the medical fee guidelines for Workers' Compensation Specific Services.
5. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
6. Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical claim.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 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.

Issues

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. The insurance carrier denied the disputed services with claim adjustment reason codes: 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 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.

   No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the health care provider was required to submit the medical bill not later than 95 days after the date the disputed services were provided.

2. 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.

Review of the submitted information finds sufficient documentation to support that a medical bill was submitted within 95 days from the date the services were provided. Consequently, 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).

Payment is calculated in accordance with 28 Texas Administrative Code §134.204(c), (k), and (l); The Work Status Report payment is calculated in accordance with 28 Texas Administrative Code §129.5.

Requestor billed CPT Code 99456-W5-NM. In accordance with 28 Texas Administrative Code §134.204(c) an examining doctor, other than the treating doctor, shall bill using CPT Code 99456 and reimbursement shall be $350.00. Reimbursement in the amount of $350.00 is recommended.

The requestor also billed CPT Code 99456-W8-RE. In accordance with 28 Texas Administrative Code §134.204(k) when conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE." In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Reimbursement in the amount of $350.00 is recommended.

The Requestor also billed CPT Code 99080-73 – Work Status Report. In accordance with 28 Texas Administrative Code §129.5(i) reimbursement in the amount of $15.00 is 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 $865.00.

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 $865.00 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	June 11, 2015 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, 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 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.