



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

ABDUL R ITANI DO

Respondent Name

STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number

M4-15-3383-01

Carrier's Austin Representative

Box Number 45

MFDR Date Received

June 12, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claims originally were submitted to the wrong carrier. The claims were not returned and we did not receive an EOB with a denial. The error was found when making status call to carriers. The patient's account was updated and the claims were rebilled with proof of timely filing. The claims have been DENIED twice with the explanation of "time limit for filing has expired."

Amount in Dispute: \$670.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office received an initial medical bill on 1/23/2015 for dates of service 8/6/2014, 9/3/2014 and 10/8/2014, an audit was performed and a denial for 29 - Time limit for filing has expired. A complete request for reconsideration was received on 4/20/2015; an audit was performed resulting in a denial being issued for 29 - Time limit for filing has expired. Upon review of the requestor's dispute packet, the Office was not able to locate evidence to substantiate the requestor's statement that the billing was initially submitted to an incorrect carrier for payment nor is there evidence to substantiate what date the requestor was notified by that carrier that the provider's billing had been submitted in error to an incorrect carrier. The requestor's statement of "our initial claim was printed and mailed on 8/14/2014. The mailing address was incorrect, is not substantive evidence that the claim was received within 95 days from date of service to the incorrect carrier and further submitted to the correct carrier within 95 days from the date of notification of submitted error."

Response Submitted by: SORM (State Office of Risk Management)

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: August 06, 2014; September 03, 2014 and October 08, 2014; CPT Code 99203, 99212 and 99213; \$670.00; \$0.00

## **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. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
5. Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical claim.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 29 – The time limit for filing has expired
  - 937 – Service(s) are denied based on HB7 provider timely filing requirements. A provider must submit a medical bill to the insurance carrier on or before the 95<sup>th</sup> day after the date of service
  - W3 – Additional payment made on appeal/reconsideration

### **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.”; 937 – “Service(s) are denied based on HB7 provider timely filing requirements. A provider must submit a medical bill to the insurance carrier on or before the 95<sup>th</sup> day after the date of service” and W3 – “Additional payment made on appeal/reconsideration.” 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 no sufficient 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).

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

**ORDER**

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 requestor is entitled to \$0.00 reimbursement for the disputed services.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

7/17/15  
\_\_\_\_\_  
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.**