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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Brian C. Buck, M.D.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-16-1368-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
January 25, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The invoice was submitted on time and timely responses were made to all EOBs. A correction was made to the invoice, which is considered a modified invoice, not a new invoice."

Amount in Dispute: $350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual received a second 'Revised' bill on 7/9/15… This bill had the 'NM' attached to 99456 and with a different dollar amount. Texas Mutual believed this to be a new bill that… was past the 95 days prescribed by Rule 133.20. Texas Mutual denied it absent timely bill submission."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 25, 2015	Required Medical Examination (99456-NM)	$350.00	$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 §133.250 sets out the procedures for requests for reconsideration of medical bills.
4. 28 Texas Administrative Code §102.4 establishes rules for non-Commission communications.
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:
   - 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-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.

Issues

1. What are the disputed services?
2. What 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 Medical Fee Dispute Resolution Request (DWC060) lists the Treatment or Service Codes in Dispute as 99456NM and 99456RE. The requestor is seeking $350.00 for 99456NM and $0.00 for 99456RE. Therefore, only procedure code 99456NM will be considered for this dispute.

2. The insurance carrier denied the disputed service 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 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 service was provided.

3. 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 documentation to support that a medical bill for the disputed service was submitted within 95 days from the date the services were provided. The requestor argued in their position statement that "the invoice was corrected (modified) and sent back to Texas Mutual." 28 Texas Administrative Code §133.250(d) requires that:

> A written request for reconsideration shall:
> (1) reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill;

Review of the submitted documentation does not support that the medical bill for the disputed service met the requirements of 28 Texas Administrative Code §133.250(d). 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

	Laurie Garnes	February 29, 2016
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.