



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

Jared Rosenberg, D.C.

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-16-1393-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

January 25, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "AN ORIGINAL BILL AND A RECONSIDERATION WERE SUBMITTED. THE CURRENT RULES ALLOW REIMBURSEMENT."

Amount in Dispute: \$350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual does not find convincing the argument or the evidence by the requestor for timely bill submission."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 16, 2015	Designated Doctor Examination	\$350.00	\$350.00

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
- Texas Labor Code §408.027 sets out the requirements for payment of a health care provider.
- 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.

Issues

- 1. Is the insurance carrier’s reason for denial of payment supported?
- 2. What is the maximum allowable reimbursement (MAR) for the disputed service?
- 3. Is the requestor entitled to reimbursement for the disputed service?

Findings

- 1. The insurance carrier denied disputed services with claim adjustment reason code 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.”

Texas Labor Code §408.027(a) requires that:

A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. 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.

Review of the submitted information supports that the requestor submitted a medical bill within 95 days of the date on which the health care services were provided to the injured employee. The insurance carrier’s denial reason is not supported. The disputed services will therefore be reviewed in accordance with 28 Texas Administrative Code §134.204.

- 2. 28 Texas Administrative Code §134.204(j)(2)(A) states, “If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection. Modifier ‘NM’ shall be added.” 28 Texas Administrative Code §134.204(j)(3)(C) states, “An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350.”

Submitted documentation supports that the requestor was a designated doctor and found that the injured employee was not at maximum medical improvement. The submitted HICF Form 1500 finds that the requestor billed the service with procedure code 99456-NM. Therefore, the MAR for this service is \$350.00.

- 3. The total MAR for the disputed service is \$350.00. The insurance carrier paid \$0.00. A reimbursement of \$350.00 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 \$350.00.

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 \$350.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Laurie Garnes
Medical Fee Dispute Resolution Officer

February 19, 2016
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.