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
James S. Golden, D.C.

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-16-1789-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
February 26, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim for $800.00 remains unpaid."

Amount in Dispute: $800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office received an initial medical bill on 12/2/2015 for dates of service 9/28/2015, whereas upon completion of a clean claim review it was determined that the provider billed with ICD-10 codes which were not applicable for the date at which services were rendered. The bill was returned to the provider with a letter educating the provider that for dates of service prior to 10/1/2015 the billing must reflect the required ICD-9 codes.

Further research found that on 1/6/2016, the Office received a corrected claim for the disputed date of service which denied the charges for 29-Time limit for filing has expired. This bill was considered a new bill as the previous submission was submitted utilizing invalid diagnosis codes. To date there is not a request for reconsideration of file for the denial that was mailed on 1/28/2016."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 28, 2015	Referral Doctor Examination to Determine Maximum Medical Improvement & Impairment Rating	$800.00	$800.00

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 §102.3 sets out the requirements for computation of time.

3. 28 Texas Administrative Code §133.10 sets out the requirements for a complete medical bill.
4. 28 Texas Administrative Code §133.20 sets out the procedures for submission of a medical bill.
5. 28 Texas Administrative Code §133.200 sets out the procedures required when an insurance carrier receives a medical bill from a health care provider.
6. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of a medical bill.
7. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
8. Texas Government Code §662.003 defines the dates considered national and state holidays.
9. 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 time filing requirement.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the maximum allowable reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes 29 – "THE TIME LIMIT FOR FILING HAS EXPIRED," and 937 – "SERVICE(S) ARE DENIED BASED ON HB7 PROVIDER TIME FILING REQUIREMENT." 28 Texas Administrative Code §133.20(b) states, in relevant part, "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."

   Further, 28 Texas Administrative Code §133.20(g) states, "Health care providers may correct and resubmit as **a new bill** [emphasis added] an incomplete bill that has been returned by the insurance carrier." Review of the submitted information supports that the requestor corrected the medical bill that had been returned as incomplete and resubmitted a new bill on January 4, 2016.

   28 Texas Administrative Code §102.3(a) states:

   > Due dates and time periods under this Act shall be computed as follows:
   > (1) computing a period of days. In counting a period of time measured by days, the first day is excluded and the last day is included.
   > (2) computing a period of months. If a number of months is to be computed by counting the months from a particular day, the period ends on the same numerical day in the concluding month as the day of the month from which the computation is begun, unless there are not that many days in the concluding month, in which case the period ends on the last day of that month.
   > (3) unless otherwise specified, if the last day of any period is not a working day, the period is extended to include the next day that is a working day.

   The division finds that the 95th day from the date of service was January 1, 2016. A working day is defined by 28 Texas Administrative Code §102.3(b) as, "any day, Monday-Friday, other than a national holiday as defined by Texas Government Code, §662.003(a) and the Friday after Thanksgiving Day, December 24th and December 26th…"

   Texas Government Code, §662.003(a) includes the "first day of January, 'New Year's Day,'" as a national holiday. Therefore, this day is not a working day and the deadline for filing this medical bill is extended to include the next day that is a working day. The next day that is a working day is January 4, 2016. Therefore, the insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. Per 28 Texas Administrative Code §134.204(j)(3), "The following applies for billing and reimbursement of an MMI evaluation… (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation supports that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the correct MAR for this examination is $350.00.

   Per 28 Texas Administrative Code §134.204(j)(4),

The following applies for billing and reimbursement of an IR evaluation …

(C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.

(i) Musculoskeletal body areas are defined as follows:

(I) spine and pelvis;

(II) upper extremities and hands; and,

(III) lower extremities (including feet).

(ii) The MAR for musculoskeletal body areas shall be as follows…

(II) If full physical evaluation, with range of motion, is performed:

(-a-) $300 for the first musculoskeletal body area.

(-b-) $150 for each additional musculoskeletal body area.

The submitted documentation indicates that the requestor provided an impairment rating and performed a full physical evaluation with range of motion for the left upper extremity and left lower extremity. Therefore, the correct MAR for this examination is $450.00.

3. The total MAR for the disputed services is $800.00. The insurance carrier paid $0.00. A reimbursement of $800.00 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 $800.00.

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 in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $800.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	May 12, 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.