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
TEXAS HEALTH HARRIS METHODIST HOSPITAL HEB

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-17-2038-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 3, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per Rule 134.403 section E all HCPC's that are paid per the fee schedule should pay per the APC allowable at 200% regardless of the billed charges"

Amount in Dispute: $199.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor submitted a 'Corrected claim,' listing code G0463 instead of 99212, which Texas Mutual received 9/21/16. . . . Because this code listed a different code than the initial bill, it constitutes a new bill that Texas Mutual denied 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 30, 2016	Outpatient Hospital Services	$199.00	$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 §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
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:
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT
   - 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE
   - 714 – ACCURATE CODING IS ESSENTIAL FOR REIMBURSEMENT, CPT/HCPCS BILLED INCORRECTLY. CORRECTIONS MUST BE SUBMITTED W/I 95 DAYS FROM DOS
   - 725 – APPROVED NON NETWORK PROVIDER FOR TEXAS STAR NETWORK CLAIMANT PER RULE 1305.153 (C).
   - 18 – EXACT DUPLICATE CLAIM/SERVICE
   - 29 – THE TIME LIMIT FOR FILING HAS EXPIRED.
   - 224 – DUPLICATE CHARGE.
   - 731 – PER 133.20(B) PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE THE SERVICE.
   - 754 – NOT A REQUEST FOR RECONSIDERATION; DOES NOT INCLUDE SAME BILLING CODES, DOS AND/OR DOLLAR AMOUNTS AS ORIGINAL BILL PER RULE 133.250

Issues

1. Are the insurance carrier's reasons for denial of payment supported?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes:
   - 714 – ACCURATE CODING IS ESSENTIAL FOR REIMBURSEMENT, CPT/HCPCS BILLED INCORRECTLY. CORRECTIONS MUST BE SUBMITTED W/I 95 DAYS FROM DOS
   - 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.
   - 754 – NOT A REQUEST FOR RECONSIDERATION; DOES NOT INCLUDE SAME BILLING CODES, DOS AND/OR DOLLAR AMOUNTS AS ORIGINAL BILL PER RULE 133.250

   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.

   Review of the submitted information finds that, while the initial medical bill was submitted timely, the health care provider billed the evaluation and management services with procedure code 99212. Per Medicare payment policy, this code is assigned status indicator B, denoting codes not paid under Medicare's Outpatient Payment System and which may not be used on an outpatient hospital bill (bill type 12x and 13x in box 4 of the form). The insurance carrier properly denied this bill, as procedure code 99212 is not a valid code for an outpatient hospital setting.

   The provider resubmitted the bill as a corrected claim, with a different code for the same services: G0463. While this code is a valid code and payable in an outpatient setting, the provider did not timely submit the new bill within 95 days from the date of service. No information was found to support that the provider met any of the exceptions for late filing provided in Labor Code Section 408.0272(b) listed above.

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."

Review of the submitted information finds that the bill for procedure code G0463 was not 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). Accordingly, the insurance carrier's denial reasons are supported. No additional payment can be recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The Division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	March 27, 2017
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 Rule §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. **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.