



**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**

STEPHEN J. RINGEL, MD

**Respondent Name**

TEXAS MUTUAL INSURANCE CO

**MFDR Tracking Number**

M4-18-2335-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

MARCH 1, 2018

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "The enclosed claim has remain unpaid. Initially submitted at the request of the treating doctor and the insurance company. We received no response so a resubmission was sent within the time frame. After researching through Texas Mutual web site the EOMB was sent to the wrong address and the claim was unpaid most probably because of a wrong icd indicator which was corrected. After resubmission it was again denied. I believe this is a clean claim, submitted in a timely manner and should be paid."

**Amount in Dispute:** \$350.00

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The requestor at the request of the treating doctor assessed the claimant not to be at MMI. The requestor billed this with code 99456WP. Texas Mutual denied payment absent consistent coding with the fee schedule. (Attachment) The requestor submitted the bill again. Texas Mutual denied it as a duplicate. The requestor submitted a third bill that Texas Mutual received 1/23/18. The coding was 99456NM. However, since this was different coding than on the initial and supplicate bills, it constituted a new bill subject to the 95 day submission prescribed by Rule 133.20. For this reason Texas Mutual denied payment of this new bill as untimely. Review of Rule 133.20 and 413.0272 of the Labor Code shows it does not meet the exceptions for untimely bill submission."

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 24, 2017	CPT Code 99456-NM	\$350.00	\$0.00

**FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 §133.10, effective April 1, 2014 sets out the requirements for submitting a complete medical bill.

3. 28 Texas Administrative Code §133.240, effective March 20, 2014, sets out the medical bill processing and audit procedures.
4. 28 Texas Administrative Code §133.20 sets out the health care providers billing procedures.
5. 28 Texas Administrative Code §133.250 sets out the medical bill processing and audit by insurance carriers procedures.
6. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
7. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
8. The services in dispute were reduced / denied by the respondent with the following reason codes:
  - CAC-29-The time limit for filing has expired.
  - 715-Service previously billed with different/incorrect codes, provider, claim, etc. processed as correction only-no addtl payment.
  - 731-Per Rule 133.20(B) provider shall not submit a medical bill later than the 95<sup>th</sup> day after the date the services are provided.
  - CAC-18-Exact duplicate claim/service.
  - 877-Bill previously processed. Refer to rule 133.250 regarding request for reconsideration.
  - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

### **Issues**

Are the disputed services dated July 24, 2017 eligible for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307?

### **Findings**

According to the DWC-60, the requestor is seeking reimbursement for CPT code 99456-NM rendered on July 24, 2017.

Whether the requestor's medical fee dispute is eligible for review relies upon whether the requestor satisfied the relevant prerequisite requirements as follows:

- 28 Texas Administrative Code §133.20( f) states" Health care providers shall not resubmit medical bills to insurance carriers after the insurance carrier has taken final action on a complete medical bill and provided an explanation of benefits except in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills)."
- 28 Texas Administrative Code §133.20(g) states " Health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier."
- 28 Texas Administrative Code §133.240(a) states "An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation."
- 28 Texas Administrative Code §133.250(d) states "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."
- 28 Texas Administrative Code §133.250(i) states "If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills)."
- Texas Labor Code §408.027(a) states, "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."
- 28 Texas Administrative Code §102.4(h), states, "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.”

A review of the submitted documentation finds the following:

- The requestor originally billed CPT code 99456-WP.
- The respondent denied reimbursement for CPT code 99456-WP based upon reason codes “CAC-P12,” “CAC-16,” “225,” and “892.” The division finds the requestor took final action after conducting bill review on a complete medical bill per 28 Texas Administrative Code §133.240(a).
- The requestor submitted a reconsideration bill for CPT code 99456-WP.
- The respondent denied the reconsideration bill for CPT code 99456-WP with reason codes “CAC-18” and “224.”
- The requestor submitted a third bill with CPT code 99456-NM. On this bill, the modifier was changed; therefore, this bill is considered a new bill per 28 Texas Administrative Code §133.20(g).
- The requestor did not submit any evidence such as a fax, personal delivery, electronic transmission, or certified green cards to support the bill was sent to Texas Mutual Insurance Co. in accordance with Texas Labor Code §408.027(a). The division concludes the respondent’s denial of payment based upon reason code “CAC-29” is supported.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that 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**

_____	_____	3/22/2018
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, 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 MDR 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.**