



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

Dr. Michael M Heckman MD

Respondent Name

Safety National Casualty Corp

MFDR Tracking Number

M4-19-2826-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

January 22, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We sent in notes to show the office visit was for an evaluation. The injection was not planned. It was decided after the visit the injection was needed for pain control so both the evaluation and injection should have been paid."

Amount in Dispute: \$200.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Michael M. Heckman, MD is an in-network member of the CorVel Texas CorCare Certified Network effective 09/13/12... The complaint process outlined in Texas Insurance Code Subchapter I, §1305.403 - §1305.405 may be the appropriate administrative remedy to address fee matters related to health care certified networks."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: April 11, 2018, 99213 -25, \$200.00, \$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 requirements of medical bill submission.
3. Texas Labor Code 408.0272 sets out the workers compensation timely billing and exceptions guidelines.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
• 29 – The time limit for filing has expired

**Issues**

- 1. Are the insurance carrier’s reasons for denial or reduction of payment supported?

**Findings**

- 1. The requestor is seeking \$200 for code 99213 for date of service April 11, 2018.

Review of the original medical bill included with this dispute indicates a date of service April 12, 2018. The carrier paid this claim on May 11, 2018.

The insurance carrier denied date of service of April 11, 2018 as 29 - “Time limit for filing claim/bill has expired.” The explanation of benefits indicates the insurance carrier received the claim on July 17, 2018 and August 7, 2018.

28 TAC §133.20 (b) states in pertinent part,

(b) 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.

Texas Labor Code 408.0272. (b) and (c) states in pertinent part,

(b) 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;

(2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

Insufficient evidence was found to support an exception to the timely filing of the April 11, 2018 date of service in dispute. The carrier’s denial is supported.

**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 \$0.00.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
February 15, 2018  
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.**