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
PAIN AND RECOVERY CLINIC

Respondent Name
CONTINENTAL CASUALTY CO

MFDR Tracking Number
M4-19-3751-01

Carrier's Austin Representative
Box Number 57

MFDR Date Received
APRIL 9, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our facility has been having difficulties with the above carrier in processing these authorized services which were denied for lack of precertification."

Amount in Dispute: $1,500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Untimely Submittal of Bill within 95 days of service."

Response Submitted by: Law Office of Brian J. Judis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 18, 2018 September 19, 2018	CPT Code 97799-CP-CA-GP Chronic Pain Management Program (12 Hours)	$1,500.00	$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

1. 28 Texas Administrative Code §133.307, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
3. Texas Labor Code §408.0272, effective September 1, 2007, provides for exceptions for timely submission of a claim by a health care provider.
4. The services in dispute were reduced / denied by the respondent with the following claim adjustment reason codes:

- 29-The time limit for filing has expired.
- BF08-Date(s) of service exceed (95) day time period for submission per Rule 408.027 and Bulletin No. B-0037-05A.

Issues

Does the documentation support requestor's position that the disputed bills were submitted timely?

Findings

1. The requestor is seeking payment of $1,500.00 for a chronic pain management program rendered September 18 and 19, 2018.
2. According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon reason code "29-The time limit for filing has expired."
3. To determine if the chronic pain management services are eligible for reimbursement the division refers to the following statute:
   - 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 §133.20(B) states, "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. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied. The medical bill submitted by the health care provider to the correct workers' compensation insurance carrier is subject to the billing, review, and dispute processes established by Chapter 133, including §133.307(c)(2)(A) - (H) of this title (relating to MDR of Fee Disputes), which establishes the generally acceptable standards for documentation."

   - 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."

4. Both parties to this dispute submitted documentation for consideration in support of their position. The division reviewed the documentation and finds:

   - The requestor submitted a copy of a Medisoft Network Professional -Pain and Recovery Clinic report that indicates on April 20, 2018.
   - A review of the submitted documentation does not contain any evidence such as a fax, personal delivery, electronic transmission, or certified green cards to support the bill was sent to the respondent.
   - The division finds the requestor did not sufficiently support the bill for CPT code 97799-CP-CA-GP was sent to the insurance carrier in accordance with Texas Labor Code §408.027(a). The division concludes the respondent's denial of payment based upon reason code "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

		5/02/2019
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.