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
ETMC REHAB

Respondent Name
ACE AMERICAN INSURANCE COMPANY

MFDR Tracking Number
M4-19-3969-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
April 29, 2019

Response Submitted By
CorVel

REQUESTOR'S POSITION SUMMARY

"The initial bill was denied for timely filing after being received on the final day of the deadline for the ending date of service in the range, September 18, 2018."

RESPONDENT'S POSITION SUMMARY

"The requestor, ETMC Rehab did not provide proof of timely filing as required by division rule. CorVel has no record of receipt of a complete medical bill for the date of service in question until 09/18/18. … 06/14/18: CPT Code 97113 and … 06/15/18: 97110 were paid in accordance with adopted division fee guidelines …"

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
June 1, 2018 to June 15, 2018	Outpatient Physical Therapy Services	$360.99	$0.00

AUTHORITY

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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 medical bill submission procedures for health care providers.
3. 28 Texas Administrative Code §102.4 establishes rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
5. Texas Labor Code §408.0272 provides certain exceptions for untimely submission of a medical bill.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – The Time Limit for filing Claim/Bill has Expired.
   - P12 – Workers' Compensation State Fee Schedule Adj.
   - GP – Service delivered under OP PT care plan
   - RM2 – Time limit for filing claim has expired
   - W3 – Appeal/Reconsideration.

Issues

Did the requestor forfeit the right to reimbursement due to untimely submission of the medical bill?

Findings

The insurance carrier denied disputed services with adjustment codes:

- 29 – The Time Limit for filing Claim/Bill has Expired.
- RM2 – Time limit for filing claim has expired

28 Texas Administrative Code §133.20(b) requires that, except as provided in 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)(1) provides certain exceptions to the 95-day time limit for medical bill submission. A health care provider does not forfeit the right to reimbursement if the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed 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…" Texas Labor Code §408.0272(b)(2) further provides that the provider does not forfeit the right to reimbursement if "the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider."

No documentation was found to support any of the exceptions described in Texas Labor Code §408.0272(b). The provider was thus required to submit the bill no later than the 95th day after the date of service.

Texas Labor Code §408.027(a) states, "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."

The disputed service dates and corresponding last date of the timely filing period for each are:

Date of Service	Last Date for Timely Filing	Received Date	Finding	Payment Amount
June 1, 2018	Tuesday, September 04, 2018	September 18, 2018	Untimely	$0.00
June 4, 2018	Friday, September 07, 2018	September 18, 2018	Untimely	$0.00
June 7, 2018	Monday, September 10, 2018	September 18, 2018	Untimely	$0.00
June 12, 2018	Monday, September 17, 2018	September 18, 2018	Untimely	$0.00
June 14, 2018	Monday, September 17, 2018	September 18, 2018	Untimely	$0.00
June 15, 2018	Tuesday, September 18, 2018	September 18, 2018	Timely	$125.27

Review of the submitted information finds that both parties agree the initial bill was received by the insurance carrier on Tuesday, September 18, 2018. This date is later than the 95th day after the dates of service June 1, 2018 through June 14, 2018 and thus the provider has forfeited the right to reimbursement for these services.

However, date of service June 15, 2018 was timely received by the insurance carrier and will therefore be reviewed for payment in accordance with division fee guidelines.

Physical therapy code 97110 is a professional service not paid under Medicare's Outpatient Prospective Payment System but using Medicare's Physician Fee Schedule. DWC *Hospital Fee Guideline* Rule §134.403(h) requires use of the fee guideline applicable to the code on the date provided if Medicare reimburses using other fee schedules. DWC *Professional Fee Guideline* Rule §134.203(c) requires the maximum allowable reimbursement (MAR) be determined by applying Medicare payment policies modified by DWC rules. The MAR is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by a DWC conversion factor.

When more than one unit is billed of designated therapy services, Medicare policy requires the first unit of therapy with the highest practice expense be paid in full; payment for each extra therapy unit provided on that date is reduced by 50% of the practice expense (PE). Reimbursement is calculated as follows:

Procedure code 97110, June 15, 2018, has a Work RVU of 0.45 multiplied by the Work GPCI of 1 is 0.45. The practice expense RVU of 0.4 multiplied by the PE GPCI of 0.938 is 0.3752. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.796 is 0.01592. The sum is 0.84112 multiplied by the DWC conversion factor of $58.31 for a MAR of $49.05. The first unit is paid at $49.05. The PE reduced rate is $38.11 at 2 units is $76.22. The total for 3 units is $125.27. This amount is recommended.

The total allowable reimbursement for the disputed services is $125.27. The insurance carrier paid $209.43. The amount due is $0.00. No additional payment is 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 findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons stated above, the division finds the requestor has not established that additional payment is due. As a result, the amount ordered is $0.00.

ORDER

In accordance with Texas Labor Code §413.031, based on the information submitted for review, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	May 21, 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 Rule §133.307.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). The division must receive the request within twenty days of your receipt of this decision.

The request may be faxed, mailed or personally delivered either to the field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** together with any other information required by 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.