



# 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**

NEURO RESTORATIVE

**Respondent Name**

TEXAS MUTUAL INSURANCE COMPANY

**MFDR Tracking Number**

M4-19-5052-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

July 30, 2019

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "We received a denial for missing CPT code which was fixed and resent, duplicate incorrectly and next for timely filing. The claim was processed within timely filing as the first submittal was made on 10/15/18. Per TX Mutual reps, providers have 95 days from last date of service to submit the original claim and 10-month time limit. Attached please find all of the submissions that were made to Texas Mutual, along with the UB04 and authorization."

**Amount in Dispute:** \$16,575.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Texas Mutual first received a bill from NEURORESTORATIVE on 12/26/18 for disputed dates of service. The bill was denied as the facility did not include appropriate cpt codes on the bill as necessary for reimbursement for outpatient facility bill. NEURORESTORATIVE submitted a 'corrected' bill on 2/4/19 in which they added cpt code 97127. The addition of the cpt code makes it a new bill and therefore did not meet the 95-day rule from date of service per Rule 133.20(b)... The rationale given by the requestor for the late bill is not consistent with the Rule above. No payment is due."

**Response Submitted by:** Texas Mutual Insurance Company

#### SUMMARY OF DISPUTED SERVICE(S)

| Date(s) of Service                           | Disputed Service(s)         | Amount In Dispute | Amount Due |
|--|-----------------------------|-------------------|------------|
| September 5, 2018 through September 28, 2018 | Revenue Code 240, CPT 97127 | \$16,575.00       | \$0.00     |

#### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

#### Background

- 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
- 28 TAC §133.20 sets out the medical bill submission procedures for health care providers.
- 28 TAC §102.4 establishes rules for non-Commission communications.
- TLC §408.027 sets out the provisions related to payment of health care providers.
- TLC §408.0272 provides for certain exceptions to untimely submission of a medical claim
- Texas Insurance Code (TIC) §1305 applicable to Health Care Certified Networks.

7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - CAC-29 –The time limit for filing has expired.
  - CAC-P12 – Workers’ Compensation jurisdictional fee schedule adjustment.
  - 725 – Approved non network provider for Texas Star Network claimant per rule 1305.153 (C).
  - 894 – HCPCS/CPT codes required to determine MAR; services are not reimbursable as billed.
  - CAC-97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
  - 617 – This item or service is not covered or payable under the Medicare outpatient fee schedule.

### **Issue(s)**

1. Did the out-of-network healthcare provider meet the requirements of Chapter §1305.006?
2. What is the timely filing deadline applicable to the medical bills in dispute?
3. Is the requestor entitled to reimbursement?

### **Findings**

1. The requestor billed for revenue code 240, CPT Code 97127, rendered on September 5, 2018 through September 28, 2018, to an injured employee enrolled in the Texas Star Network, a certified healthcare network. The insurance carrier’s response indicates that the claim is in the Texas Star Network. The requestor seeks a decision from the DWC’s medical fee dispute resolution (MFDR) section as an out-of-network healthcare provider.

The insurance carrier denied/reduced the disputed charges with denial reason code “725 – Approved non network provider for Texas Star Network claimant per rule 1305.153 (C).”

The requestor filed this medical fee dispute to the DWC asking for resolution pursuant to 28 TAC (TAC) §133.307 titled *MDR of Fee Disputes*. The authority of the DWC is to resolve matters involving employees enrolled in a certified health care network, is limited to the conditions outlined in the applicable portions of the TIC, Chapter 1305 and limited application of TLC statutes and rules, including 28 TAC §133.307.

Chapter §1305.006 outlines the insurance carrier’s liability for out-of-network healthcare and states, An insurance carrier that establishes or contracts with a network is liable for the following out-of-network health care that is provided to an injured employee:

- (1) emergency care;
- (2) health care provided to an injured employee who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract; and
- (3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section [1305.103](#).

Review of the “Out of Network Authorization to Treat Injured Worker Covered by the Texas Star Network,” dated August 9, 2018, documents that the requestor, NeuroRestorative, obtained an out-of-network approval to treat the in-network injured employee. The out of network referral states in pertinent part, “The request to provide necessary medical services for the above injured worker as an out of network provider has been reviewed and approved....”

TIC §1305.153 (c) provides “Out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation.”

The DWC’s medical fee dispute resolution section may address disputes involving health care provided to an injured employee enrolled in an HCN, only if the out-of-network health care provider was authorized by the certified network to do so. The DWC finds that the requestor has therefore, met the exception outlined in Chapter 1305.006(3). As a result, the disputed services rendered on September 5, 2018 through September 28, 2018, are under the jurisdiction of the DWC and therefore, eligible for medical fee dispute resolution. The disputed services are reviewed pursuant to the applicable rules and guidelines, pursuant to TIC §1305.153(c).

2. The requestor seeks reimbursement for dates of service September 5, 2018 through September 28, 2018. The insurance carrier denied the disputed services with claim adjustment reason codes: “CAC-29 –The time limit for filing has expired.”  
28 TAC §133.20(b) requires that, except as provided in TLC §408.0272, “a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.” TLC §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.

The requestor submitted insufficient documentation to support that any of the exceptions described in TLC §408.0272 apply to the service(s) in this dispute. For that reason, the health care provider was required to submit the medical bill not later than 95 days after the date the disputed services were provided.

TLC §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." 28 TAC §102.4(h) states that: "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."

Review of the submitted information finds insufficient documentation to support that the medical bills dated September 5, 2018 through September 28, 2018 were submitted within 95 days from the date the service(s) were provided. Consequently, the requestor has forfeited the right to reimbursement due to untimely submission of the medical bill, pursuant to TLC §408.027(a).

3. The DWC finds that the requestor is not entitled to reimbursement for disputed services rendered on September 5, 2018 through September 28, 2018. As a result, the amount recommended is \$0.00.

**Conclusion**

For the reasons stated above, the DWC 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 TLC Sections 413.031 and 413.019 (if applicable), the DWC has determined that the requestor is not entitled to reimbursement for the services involved in this dispute.

**Authorized Signature**

|           |  |                           |
|-----------|--|---------------------------|
| Signature | Medical Fee Dispute Resolution Officer | September 6, 2019<br>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 TAC §133.307, 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 DWCO45M** in accordance with the instructions on the form. The request must be received by the DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 with the DWC. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 TAC §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**