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
EMERGENCHEALTH, LLC

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-19-5176-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
AUGUST 12, 2019

REQUESTOR'S POSITION SUMMARY

"we originally received this claim as self pay from the facility where our services were provided. Once we learned the patient had an open workers' compensation claim with Texas Mutual the claim was billed to them for processing, but all codes for our service were not included on that original claim to Texas Mutual. Code 6445 59 and Code 76942 26 59 were not included on the original claim. Once we learned of this error, the entire claim was resubmitted to the carrier via fax transmittal for processing. The fax was sent to the carrier within the 95 day filing deadline -the fax was sent on 04/08/19 and the 95 day deadline was 04/15/2019."

Amount in Dispute: $199.70

RESPONDENT'S POSITION SUMMARY

"The provider submitted a bill with additional billing codes and different billed amount, therefore making it a new bill and 95 day rule applies from DOS."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 10, 2019	CPT Code 64445-59	$147.60	$0.00
	CPT Code 76942-26-59	$52.10	$0.00
TOTAL		$199.70	$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 (DWC).

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. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
5. 28 Texas Administrative Code §133.20, effective January 29, 2009, sets out the health care providers billing procedures.
6. The services in dispute were reduced / denied by the respondent with the following claim adjustment reason codes:
   - CAC-29-The time limit for filing has expired.
   - 731-Per 133.20(B) provider shall not submit a medical bill later than the 95th day after the date the service.
   - CAC-W3, 350-In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
   - CAC-18-Exact duplicate claim/service.
   - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - DC4-No additional reimbursement allowed after reconsideration.
   - 224-Duplicate charge.

Issues

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

Findings

1. The requestor is seeking payment of $199.70 for professional services, CPT codes 64445-59 and 76942-26-59, rendered on January 10, 2019.

2. According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon reason code "CAC-29-The time limit for filing has expired."

3. To determine if the professional services are eligible for reimbursement the DWC refers to the following statute:

   - 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."

   - Labor Code §408.0272(b)(1) states "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."

   - 28 TAC §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 TAC §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 TAC §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 DWC reviewed the documentation and finds:

    - The date of service in dispute is January 10, 2019.
    - The respondent denied reimbursement for the professional services based upon timely filing.
    - The requestor wrote "Code 6445 59 and Code 76942 26 59 were not included on the original claim. Once we learned of this error, the entire claim was resubmitted to the carrier via fax transmittal for processing. The fax was sent to the carrier within the 95 day filing deadline -the fax was sent on 04/08/19 and the 95 day deadline was 04/15/2019."
    - On April 8, 2019, the provider added codes and resubmitted the bill to Texas Mutual Insurance Co. Per 28 Texas Administrative Code §133.20 a corrected bill is considered as a new bill; therefore, this bill was submitted past the 95 day deadline.
    - The documentation does not contain any evidence such as a fax, personal delivery, electronic transmission, or certified green cards to support the corrected bill was sent to the respondent within the 95 day deadline.
    - The requestor did not sufficiently support that the corrected bill was submitted to the respondent within the 95 day deadline set out in Labor Code §408.027(a) and 28 TAC §133.20(B).
    - The respondent's denial of payment based upon timely filing is supported.

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 Texas Labor Code §413.031, the DWC has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		09/11/2019
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 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 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 DWC. **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.