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
INTEGRITY PAIN & WELLNESS

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-20-2376-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 26, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: We initially submitted the claim on 07/08/2019 (attached) and it was not received, then we submitted the claim fax #512-224-3889 (attached) on 08/26/2019. After that claim got denied stating that "The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information." So far that we downgraded the procedure code 99214 to 99213 and submitted the corrected claim on 10/03/2019 but still was not received by insurance. Called the claim department on 10/21/2019 as per the representative we need to send and appeal because it has passed the timely filing limit for the corrected claim. We also submitted the appeal but it was denied.

Amount in Dispute: $438.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider changed the cpt code from 99214 to 99213, corrections to a medical bill involving a cpt code becomes a new bill and is subject to the 95 day rule from the date of service per Rule 133.20(b)(c)."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
June 28, 2019	Code 99213	$438.00	$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 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:
   - CAC-193 Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - CAC-29 The time limit for filing was expired
   - CAC-W3 In accordance with TDI-DWC Rule 134.904, this bill has been identified as a request for reconsideration or appeal
   - 891 – No additional payment after reconsideration
   - 731 – Per 133.20(B) Provider shall not submit a medical bill later than the 95th day after the date the service
   - 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

Issues

1. What is the timely filing deadline applicable to the medical bills for the disputed services?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. The insurance carrier denied the disputed services with claim adjustment reason codes: CAC-193 Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly, CAC-29 The time limit for filing was expired, CAC-W3 In accordance with TDI-DWC Rule 134.904, this bill has been identified as a request for reconsideration or appeal, 891 – No additional payment after reconsideration, 731 – Per 133.20(B) Provider shall not submit a medical bill later than the 95th day after the date the service and350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal."

   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) provides certain exceptions to the 95-day time limit for bill submission:

   > 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.

   Documentation provided does not support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the health care provider was required to submit the medical bill not later than the 95th day following the date the disputed services were provided.

2. Texas Labor Code §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 Texas Administrative Code §102.4(h) provides 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 documentation does not support that a medical bill was submitted within 95 days from the date the services were provided. Consequently, the requestor has forfeited the right to reimbursement due to untimely submission of the medical bill, pursuant to Texas Labor Code §408.027(a).

Conclusion

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

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

[redacted]	[redacted]	June 24, 2020
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, 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.