Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDING AND DECISION

GENERAL INFORMATION

Requestor Name
MARK ANTHONY GARZA, MD

Respondent Name
CITY OF FORT WORTH

MFDR Tracking Number
M4-20-2422-01

Carrier's Austin Representative
Box Number 4

MFDR Date Received
JUNE 4, 2020

REQUESTOR'S POSITION SUMMARY

"We are requesting that this claim be reviewed one more time, as the original claim was billed according the information we received on the authorization for the treatment. This authorization was dated 10/9/19, which was after the PLN 11 was issued on 10/1/19, and it had the same diagnosis listed that we billed on the original claim. We were not made aware that the PLN 11 even existed until AFTER our original claim was denied. Once we were made aware of the PLN 11, we submitted a corrected claim and it was denied for timely filing, even though we were within the 10 months to file an appeal."

Disputed Amount: $1,340.60

RESPONDENT'S POSITION SUMMARY

"After review, the original audit was maintained with a denial for extent of injury…The provider submitted a corrected claim that was received on 03/10/2020 but removed/changed the diagnosis code thus making it a new bill and was subjected to the 95th day timely filing rule which denied for the time limit for filing had expired."

Response Submitted By: Sedgwick

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 19, 2019	CPT Code 64493	$899.45	$0.00
	CPT Code 64494	$441.15	$0.00
TOTAL		$1,340.60	$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 (TAC) §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. 28 TAC §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
4. 28 TAC §133.20, effective January 29, 2009, sets out the health care providers billing procedures.
5. 28 TAC §133.10, effective April 1, 2014, sets out the required billing forms/formats.
6. 28 TAC §133.240, effective March 30,2014, sets out the medical bill process for payment and denials.
7. 28 TAC §133.250, effective March 30,2014, sets out the reconsideration of payment of medical bill process
8. The services in dispute were reduced / denied by the respondent with the following reason codes:

Explanation of Benefits dated December 18, 2019

- 167-This (These) diagnosis(es) is (are) not covered.
- Diagnosis code(s) are not for the allowed conditions in the claim.

Explanation of Benefits dated January 30, 2020

- 219-Based on extent of injury.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3-Reporting purposes only.

Explanation of Benefits dated March 31, 2020

- 29-The time limit for filing has expired.
- The provider has resubmitted this bill, but has removed/changed the diagnosis code, CPT/HCPCS code(s), POS and/or total bill charge amount, this making it a new bill and subject to the 95 day timely filing rule.

Issues

1. Does an extent of injury issue exist in this dispute?
2. Is the respondent's denial of payment based upon timely filing supported?
3. Is the requestor entitled to reimbursement for services rendered on November 19, 2019?

Findings

1. The requestor is seeking payment of $1,340.60 for CPT codes 64493 and 64494 rendered on November 19, 2019.

2. The requestor's original and reconsideration bill for CPT codes 64493 and 64494 lists the diagnosis of [redacted]. The respondent denied reimbursement for these codes based upon "167-This (These) diagnosis(es) is (are) not covered," and "Diagnosis code(s) are not for the allowed conditions in the claim," and "219-Based on extent of injury."

   The requestor noted, "On 3/10/20 we sent the carrier a corrected claim with the diagnosis codes updated to reflect the PLN11 and it was denied for timely filing." This fact is supported by the March 31, 2020 Explanation of Benefits that indicates diagnosis codes "," and "."

   Based upon the March 31, 2020 Explanation of Benefits, the respondent did not maintain the denial of extent of injury and denied the services based upon timely filing; therefore, an extent of injury issue does not exist in this dispute.

3. The respondent wrote, "The provider submitted a corrected claim that was received on 03/10/2020 but removed/changed the diagnosis code thus making it a new bill and was subjected to the 95th day timely filing rule which denied for the time limit for filing had expired."

4. To determine if the disputed services are eligible for reimbursement the DWC 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 TAC §133.10(f)(1)(R) states, "All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form. (1) The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care: (R) diagnosis pointer (CMS-1500, field 24E) is required."

- 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 §133.240(a) states, "An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation."

- 28 TAC §133.250(a) states in part, "If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill, the health care provider may request that the insurance carrier reconsider its action."
- 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."

- Per the Texas Register Preamble, "Section 133.250(d)(1). Comment: Commenters recommend subsection 133.250(d)(1) be amended to require modifiers and number of units in addition to the original billing codes. Agency Response: The Division declines to make the requested change. A reconsideration request may include corrections relating to modifiers and/or number of units. For this reason, a request for reconsideration may include changes in the number of units or modifiers from that in the original bill for proper processing and payment of the bill."

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

    - The date of service in dispute is November 19, 2019.
    - Both parties agree that the requestor's original and reconsideration bill list diagnosis code.
    - The respondent took final action on these completed medical bills and provided explanation of benefits in accordance with 28 TAC §133.240 and §133.250.
    - The requestor changed the diagnosis code on the third bill.
    - Per 28 TAC §133.10(f)(1)(R), the diagnosis code is a required element for a complete bill.
    - The Preamble clarified that only modifiers and number of units may be amended from the original bill.
    - Per 28 TAC §133.20(g) the corrected diagnosis is a new bill.
    - The requestor noted "On 3/10/20 we sent the carrier a corrected claim." The bill was 112 days past the date of service.
    - The requestor did not support that the claim was submitted to the respondent within the 95 day deadline set out in Texas Labor Code §408.027(a) and 28 TAC §133.20(b).
    - The respondent's denial of payment based upon timely filing is supported.
    - The requestor is not due reimbursement for CPT code 64493 and 64494.

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

Signature	[redacted] Medical Fee Dispute Resolution Officer	06/26/2020 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.