TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Elite Healthcare North Dallas

Respondent Name
Texas Mutual Insurance Co.

MFDR Tracking Number
M4-22-0898-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
January 13, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 10, 2021 May 11, 2021 May 12, 2021 May 13, 2021 May 17, 2021	CPT Code 97545-WH	$102.40/ea	$0.00
	CPT Code 97546-WH	$307.20/ea	$0.00
	Total	$2,048.00	$0.00

Requestor's Position

"I have attached the original claim with the original date that it was sent to you for each of these dates of service…I have attached another DOS from 5/18/2021 that was under the same preauth that Texas Mutual paid in full. This is the second time we have reconsidered with proof of timely filing for your review. Please process these for payment as you have for the other dates of service under the same preauthorization."

Amount in Dispute: $2,048.00

Respondent's Position

"Research confirms the provider first submitted the bill with cpt code 97545/WC and 97546/WC. Audit staff reviewed the billing and preauthorization and denied

the bill for no preauth due to Work Hardening being certified not Work Conditioning. Audit is consistent and in accordance with Rule 134.204 and Rule 134.230. The provider attempted to submit a request for reconsideration, however due to the changes on the bill such as modifier and total billed charges, the bill is considered a new bill submission and subject to timely filing guidelines per Rule 133.20(b)."

Response Submitted By: Texas Mutual Insurance Company

Findings and Decision

Authority

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

Statutes and Rules

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.600 requires preauthorization for specific non-emergency healthcare and services.
3. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
4. 28 TAC §133.20 sets out the rule for medical bill submission.
5. 28 TAC §133.10 sets out the required billing forms/formats.
6. 28 TAC §133.240 sets out the medical bill process for payment and denials.
7. 28 TAC §133.250 sets out the reconsideration of payment of medical bill process.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- CAC-197-Pre-Certification/authorization/notification absent.
- 930-pre-authroization required, reimbursement denied.
- CAC-29-The time limit for filing has expired.
- 731-Per Rule 133.20(B) providers shall not submit a medical bill later than the 95th day after the date the service.

Issues

1. Is Texas Mutual's denial based on a lack of preauthorization supported?

2. Is Texas Mutual's denial based on timely filing supported?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $2,048.00 for CPT codes 97545-WH and 97546-WH rendered from May 10 through 17, 2021.

   The requestor initially billed for the disputed services as work conditioning with CPT codes 97545-WC and 97546-WC.

   The respondent denied reimbursement based upon a lack of preauthorization.

   28 TAC §134.600 (p)(4) states, "Non-emergency health care requiring preauthorization includes: (4) all work hardening or work conditioning services."

   On April 28, 2021, the respondent preauthorized 80 hours of work hardening.

   Because the respondent billed for a work conditioning program, the respondent's denial of payment based upon a lack of preauthorization is supported.

2. The respondent also denied reimbursement for the disputed services based upon "CAC-29-The time limit for filing has expired."

   To determine if the disputed services are eligible for reimbursement the DWC refers to the following statute:

   - TLC §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 §133.20(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 §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."

- 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(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.

- 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."

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

- The requestor initially billed for the disputed services with the WC modifier with charges of $57.60 for 97545-WC and $172.80 for 97546-WC. 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 original bill was submitted within the 95-day deadline.

- On the reconsideration bill, the requestor changed the modifier from WC to WH and the charges to $102.40 for 97545-WH and $307.20 for 97546-WH.

- The EOB dated December 22, 2021 denied payment for the work hardening program based upon timely filing.

- The respondent wrote, "due to the changes on the bill such as modifier and total billed charges, the bill is considered a new bill submission and subject to timely filing guidelines per Rule 133.20(b)."

- The Preamble clarified that only modifiers and number of units may be amended from the original bill. The requestor changed the modifier and the charges.
- Per 28 TAC §133.20(g)to the corrected charges constitute a new bill.
- The requestor did not support that the new 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 based upon timely filing is supported.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	04/13/2022 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.