



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 FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Musculoskeletal Institute of LA

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-14-0600-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

October 18, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Attached is the Medical Fee Resolution request reflecting the charges denied by Texas Mutual. Following is the first EOB we received denying codes as being invalid. It is not in our policy to accept Texas work comp patients. However, in this case an exception was made because it was a referral. Louisiana does not recognize 2013 CPT Codes for EMG/NCS. When our computer rejected the 2013 codes they were changed to the Louisiana Codes. It was not until we got this denial that we learned Texas will take the new codes. We are requesting an exception to the filing limit in this case due to a clerical error in not recognizing Texas Comp guidelines."

Amount in Dispute: \$1536.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 5/23/13.

The requestor billed Texas Mutual codes 99070, 95904, 95900, 95861, and 99245 for services provided on the date above. Texas Mutual received the bill 6/11/13... Texas Mutual denied payment of 99070 because it has a status 'B' under Medicare. The AMA and Medicare discontinued use of codes 95900 and 95904 in January 2013, which was the basis of Texas Mutual's denial of the these two codes. The requestor tested multiple muscles of the upper extremities then billed this with code 95861(2). Texas Mutual declined to issue payment when there is another more specific code that reflects such multiple muscle testing of the extremities. Medicare discontinued coverage of code 99242 in January 2010. Hence, Texas Mutual's denial of this code.

The requestor submitted a 'Corrected Claim' for 'Reconsideration.'... Texas Mutual received this bill 10/2/13. This bill listed codes 95886, 95911, and 99202. This bill was neither a corrected claim nor a reconsideration bill; it was a new bill that Texas Mutual denied as untimely.

No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 23, 2013	EMG/NCS (99070, 95886, 95911) Evaluation & Management, New Patient (99202)	\$1536.00	\$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.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for billing and reimbursing professional medical services.
3. 28 Texas Administrative Code §133.250 sets out the procedures for reconsideration payment of medical bills.
4. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
5. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
6. Texas Labor Code §408.027 sets out the rules for timely submission of claims by health care providers.
7. Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical bill.
8. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - From Explanation of Benefits dated 7/17/13, for CPT Code 99070:
 - CAC-W1 – Workers Compensation State Fee Schedule Adjustment
 - CAC-97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
 - 217 – The value of this procedure is included in the value of another procedure performed on this date.
 - 284 – No allowance was recommended as this procedure has a Medicare status of “B” (Bundled).
 - 892 – Denied in accordance with DWC Rules and/or Medical Fee Guideline including current CPT Code descriptions/instructions.
 - From Explanation of Benefits dated 10/4/13, for CPT Codes 95886, 95911, & 99202:
 - CAC-29 – The time limit for filing has expired.
 - 731 – Per 133.20 provider shall not submit a medical bill later than the 95th day after the date the service, for services on or after 9/1/05

Issues

1. Under what authority is the request for medical fee dispute resolution considered?
2. Is CPT Code 99070 payable according to 28 Texas Administrative Code §134.203?
3. What is the timely filing deadline applicable to the medical bills for the services in dispute?
4. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. The requestor is a health care provider that rendered disputed services in the state of Louisiana to an injured employee with an existing Texas Workers' Compensation claim. The health care provider was dissatisfied with the insurance carrier's final action. The health care provider requested reconsideration from the insurance carrier and was denied payment after reconsideration. The health care provider has requested medical fee dispute resolution under 28 Texas Administrative Code §133.307. Because the requestor has sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the Division concludes that it has jurisdiction to decide the issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable rules.
2. 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, “for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; ... and other payment policies in effect on the date a service is provided...” The requestor billed for services using CPT Code 99070. This code has a Medicare status of “bundled,” which means, “Payment for covered services are always bundled into payment for other services not specified... If these services are covered, payment for them is subsumed by the payment for the services to which they are incident.” Therefore, this charge is not payable according to 28 Texas Administrative Code §134.203 and no recommendation for reimbursement of this charge is made.
3. 28 Texas Administrative Code §133.20(b) requires that, except as provided in Texas 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.” No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided.
4. Texas Labor Code §408.027(a) states, in pertinent part, 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) 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 documentation to support that a medical bill was submitted on 9/3/2013. 28 Texas Administrative Code §133.250 (d) states that a written reconsideration request shall "(1) reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill." Because the billing codes were changed, the submission was a new bill. Documentation does not support that this new bill was filed within 95 days from the date the services were provided. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor has forfeited the right to reimbursement due to untimely submission of the medical bill for the disputed services.

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 upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	February 18, 2015
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 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 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 Division. **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.