TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Ranil Ninala, M.D.

Respondent Name
ACE American Insurance Co.

MFDR Tracking Number
M4-25-0813-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
December 9, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 14, 2024	Examination to Determine Maximum Medical Improvement and Impairment Rating – 99456-WP	$800.00	$0.00

Requestor's Position

"The carrier has not paid for the attached Certifying Doctor Examination that was referred by the treating doctor who was not certified to perform MMI/IR. The carrier has not responded to multiple attempts for request for reconsideration. The carrier has not responded to multiple requests for EOB for this case.

"… The bill/claim was timely submitted by the provider and was received by the insurance carrier and/or the insurance carrier's bill review company …

"No payment and no denial or Explanation of Benefits (EOB) has been received for this bill/claim which is required per Rul 133.240 (a) to be done no later than 45 days from the date the carrier receives the bill/claim …

"Attempts to retrieve payment and/or EOB from the carrier have been made but no payment and no EOB has been received to date …

"Please see attached copy of the original claim/bill and required medical documentation for this

Certifying Doctor Examination as it was originally submitted. This includes a copy of the original bill showing the same billing codes, modifiers, dates of service and dollar amounts. We have also attached proof of original receipt of the bill/claim by the carrier and/or the carrier's bill review company which shows timely filing."

Amount in Dispute: $800.00

Respondent's Position

"Corvel, the TPA and carrier's bill review agent, did receive a bill from the HCP via vax on 6-17-24; however, as the bill was missing at least one diagnosis code (as required per rule 133.10), the bill was returned to the provider for correction … By rule, a bill is not received timely until a complete bill is submitted within 95 days from the DOS.

"Please also note in Exhibit A that the DOS listed on the CMS1500 form is 3-22-24, not 5-14-24 …

"A complete/corrected bill (diagnosis added, correct DOS) was eventually received by the carrier/bill review vendor on 10/21/24 via fax. The DOS was denied for two reasons: timely filing and non-network provider.

"CorVel maintains the Requestor, Ranil Ninala, is not entitled to reimbursement for date of service 05/14/2024 in the amount of $800 based on failure to obtain out-of-network approval from the Texas CorCare Network prior to services being rendered in accordance with TIC Sec. 1305.103(e) as well as the complete bill not being filed timely.

"As the Injured Worker (IW) is a participant in the Corvel Texas Certified Healthcare Network, the treating physician was required to refer to an in-network provider or obtain OON. As indicated in Section 1305.006 above, the carrier's liability for OON care is limited to three scenarios – none of which are applicable to the DOS in question (05/14/2024)."

Response Submitted by: CorVel Healthcare Corporation

Findings and Decision

Authority

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

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.10 sets out the procedures for completing a medical bill.

2. 28 TAC §133.20 sets out the procedures for submitting a medical bill.

3. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

Denial Reasons

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

- 242 – Services not provided by network/primary care prov
- NNP – Out-of-network approval not requested prior to rendering services.
- 29 – Time Limit for Filing Claim/Bill has Expired
- Notes: "Effective 9/1/05, providers have 95 days to submit bills to the insurance carrier for reimbursement. Your bill exceeds this limit."
- Notes: "Reimbursement is denied in accordance with Section 408.027 of the Act."
- Notes: "Per the Labor Code: 401.011(19) 'Health care' includes all reasonable and necessary medical aid, MEDICAL EXAMS, medical treatments, medical diagnoses, MEDICAL EVALUATIONS, and medical svcs. This is a medical evaluation. Claim is covered by TX CorCare HCN"
- Notes: "Per Sec 1305.006(3) a carrier is liable for out-of-network healthcare ONLY if the non-network HCP was referred from the IE's treating doctor AND that referral has been APPROVED by the network pursuant to Sec 1305.103. No OON approval submitted."

Issues

1. Is ACE American Insurance Co.'s denial based on timely filing supported?

Findings

1. Dr. Ninala is seeking reimbursement for an examination to determine maximum medical improvement and impairment rating performed on May 14, 2024. The insurance carrier denied payment, in part, based on timely filing.

   28 TAC §133.10 states, in relevant part,

   (f) All information submitted on the required 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: …

   (M) diagnosis or nature of injury (CMS-1500/field 21) is required; at least one diagnosis code and the applicable ICD indicator must be present; …

   (O) date or dates of service (CMS-1500, field 24A) is required;

28 TAC §133.20 states, in relevant part,

(a) The health care provider must submit all medical bills to the insurance carrier except when billing the employer in accordance with subsection (j) of this section.

(b) Except as provided in Labor Code §408.0272(b), (c), or (d), a health care provider must not submit a medical bill later than the 95th day after the date the services are provided.

Dr. Ninala submitted a bill to the insurance carrier on June 17, 2024, stating that it was for the examination considered in this dispute. However, evidence submitted to DWC finds that the bill received by the insurance carrier was for the date of service March 22, 2024. In addition, this bill did not contain a diagnosis code and the applicable ICD indicator.

Per a submitted document dated July 10, 2024, the insurance carrier returned this bill as incomplete, asking the requestor to provide an ICD-10 code. DWC finds that the evidence supports that the bill that the insurance carrier received was incomplete and was not for the date of service in question.

Per 28 TAC §133.20(g), "health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier."

The submitted documentation indicates that a complete bill for the date of service in question was submitted to the insurance carrier on October 21, 2024. This date is more than 95 days after the date of service.

DWC finds that the insurance carrier's denial of payment based on timely filing is supported. No reimbursement can be recommended.

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 requestor has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 5, 2025 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 three 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 tres o correo electronico CompConnection@tdi.texas.gov.