

DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and Rules of the Division of Workers' Compensation adopted thereunder.

ISSUES

A contested case hearing was held on August 6, 2009 to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the findings of Medical Fee Dispute Resolution that the health care provider is entitled to \$316.68 for CPT code 95101 (x3) for services rendered to the claimant on July 25, 2007?

PARTIES PRESENT

Petitioner/Carrier appeared and was represented by HW, adjuster. Respondent/Provider appeared and was represented by WC, lay representative. Claimant died on January 29, 2009.

BACKGROUND INFORMATION

On July 25, 2007, Respondent/Provider provided three units of psychotherapy services to the Claimant for his compensable injury. Petitioner/Carrier denied reimbursement because the bill was not timely submitted and because of the absence of pre-certification/authorization. The Medical Fee Dispute Resolution Officer determined that the Respondent/Provider did timely submit the bill and was entitled to medical fees in the amount of \$316.68. Petitioner appeals the adverse determination.

Texas Labor Code Section 408.027(a) states as follows:

"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."

The 95th day after the date the services were rendered was October 28, 2007. The Respondent argues that in accordance with Division Rule 102.4(h) the bill was timely submitted based on the date the CMS-1500 was signed by the doctor. The carrier argues that because no postmark is available, the date it was received by the carrier minus five days should control. Rule 102.4 (h) states as follows:

"(h) 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."

In evidence at the Medical Contested Case Hearing was a copy of the CMS-1500 form that was submitted by the Provider to the Carrier. The form is electronically signed by Dr. B and dated August 13, 2007. The Respondent states that the signature date on the CMS-1500 form should be used as the date the item was sent because a postmark date is unavailable.

If there had been no other evidence of the date the CMS-1500 was received by the Carrier then the date on the CMS-1500 may have been sufficient on its face to establish when the bill was sent to the Carrier. However, there is an electronic stamp from the Carrier contained on the CMS-1500 form that indicates it was received by the Carrier on January 4, 2008. Thus, the CMS-1500 form is deemed to have been sent five days prior to the date of receipt, i.e. on December 31, 2007. Rule 102.4 (h) requires that the later date of December 31, 2007 be used to establish the date the CMS-1500 was sent.

The Petitioner also argues that the Respondent is not entitled to reimbursement because the pre-authorization letter had expired prior to the date of service. The petitioner points to Rule 134.600(f) to support its position. Rule 134.600(f) states as follows:

"The requestor or employee shall request and obtain preauthorization from the carrier prior to providing or receiving health care listed in subsection (p) of this section. Concurrent review shall be requested prior to the conclusion of the specific number of treatments or period of time preauthorized and approval must be obtained prior to extending the health care listed in subsection (q) of this section."

Rule 134.600(f) does not appear to be applicable in the present case because the services rendered were pre-authorized and there was no evidence presented that the provider attempted to provide more services than what was pre-authorized. However, even if Rule 134.600(f) was applicable, the Provider still would not be entitled to reimbursement. The reason is because December 31, 2007 is more than 95 days after the date of service. Therefore, the Respondent's right to reimbursement was forfeited by his failure to timely submit his bill. Based upon the evidence presented in this hearing, the Petitioner has shown that the preponderance of the evidence is contrary to the decision of the Medical Fee Dispute Resolution Officer and the Respondent is not entitled to \$316.68 for services rendered on July 25, 2007.

Even though all the evidence presented was not discussed, it was considered. The Findings of Fact and Conclusions of Law are based on all of the evidence presented.

FINDINGS OF FACT

1. The parties stipulated to the following facts:
 - A. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.

- B. On _____, Claimant was the employee of (Self-Insured), Employer.
 - C. Claimant sustained a compensable injury on _____.
 - D. The Medical Fee Dispute Resolution Officer determined that the health care provider is entitled to \$316.68 for services rendered on July 25, 2007.
- 2. Carrier delivered to Provider a single document stating the true corporate name of Carrier, and the name and street address of Carrier's registered agent, which document was admitted into evidence as Hearing Officer's Exhibit Number 2.
 - 3. Respondent's claim for \$316.68 was not timely submitted to the Carrier for reimbursement in accordance with Texas Labor Code §408.027.

CONCLUSIONS OF LAW

- 1. The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction to hear this case.
- 2. Venue is proper in the (City) Field Office.
- 3. The preponderance of the evidence is contrary to the decision of the Medical Fee Dispute Resolution Officer that the health care provider is entitled to \$316.68 for CPT code 96101 (x3) for services rendered to the claimant on July 25, 2007.

DECISION

Respondent, Dr. B, is not entitled to reimbursement in the amount of \$316.68 for CPT Code 96101 (x3) for services rendered on July 25, 2007.

ORDER

Petitioner/Carrier is not liable for the medical benefits at issue in this hearing.

The true corporate name of the insurance carrier is **(SELF-INSURED)** and the name and address of its registered agent for service of process is:

**(SELF-INSURED)
JBC, SECRETARY
(STREET ADDRESS)
(CITY), TX (ZIP CODE)**

Signed this 10th day of August, 2009.

Jacquelyn Coleman
Hearing Officer