Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4812 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
BRUCE STRACH DC

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-14-0520-01

Carrier's Austin Representative Box
Box Number 54

MFDR Date Received
October 14, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "THIS LETTER IS IN RESPONSE TO THE EOB OF DENIAL OF UNTIMLEY FILING BILL FOR $1890.00 FOR THE DESIGNATED DOCTOR EXAMINATION PROVIDED BY DR. BRUCE STRACH. THE ORIGINAL BILL WAS FOR $1890.00 AND WAS FILED ON TIME. WE ARE SENDING IN OUR PROOF OF FAXE'S THAT WERE SUBMITTED ON 3/25/2013. I AM REQUESTING THAT THIS BILL BE RE-VIEWED AND REPROCESSED FOR PAYMENT. THANK YOU FOR YOUR ATTENTION TO THIS MATTER."

Amount in Dispute: $1,890.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual received the billing for this on 7/24/13. (Attachment) There was no explanation with the billing for the lateness of the bill. Absent such, Texas Mutual declined to issue payment. In its DWC-60 packet the requestor believes it has substantiated its position of timely filing. Texas Mutual is not persuaded by the fax conformations."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 28, 2013	CPT Code 99456-W5-WP, 99456MI, 99456-RE-W6, 99456-RE-W7, 99456-RE-W8 and 99080-73	$1,890.00	$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 §133.20 sets out medical bill submission procedures for health care providers.
3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of claims by health care providers.
5. Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical bill.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 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
- CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY
- CAC-29 – THE TIME LIMIT FOR FILING HAS EXPIRED
- 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824
- 731 – PER 133.20 PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE THE SERICE FOR SERVICE ON OR AFTER 9/1/05

Issues

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. 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.
2. 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 no documentation to support that a medical bill was submitted 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 reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on 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

Signature	SANDRA HERNANDEZ Medical Fee Dispute Resolution Officer	01/09/15 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 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*** along 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