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
NorthStar Anesthesia PA

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-14-1062-01

Carrier's Austin Representative Box
Box Number 54

MFDR Date Received
December 10, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This denial is incorrect as we did file these claims within time limits."

Amount in Dispute: $1,950.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "NORTHSTAR ANESTHESIA PA submitted corrected bills, i.e. place of service 22 for both providers that Texas Mutual received 6/11/13. …Because 6/11/13 is beyond 95 days from the date of service Texas Mutual declined to issue payment."

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 30, 2013	Anesthesia	$1,950.00	$829.50

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 health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
4. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC – 29 – The time limit for filing has expired.

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?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The carrier denied the disputed services as, 29 "The time limit for filing has expired." 28 Texas Administrative Code §133.20(b) states, in pertinent part, 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." Review of the submitted documents find;
    a. Medical bill with date 3/25/2013
    b. Acknowledgment of carrier via response to MFDR, "a complete bill to Texas Mutual was received (date in position statement 4/8/12) however, all other correspondence dated in the year 2013.

    Therefore, the carrier's denial is not supported.
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." Therefore, pursuant to Texas Labor Code §408.027(a), the submitted and acknowledged medical claim was within time limit and the requestor has not forfeited their right to reimbursement. The disputed services will be reviewed per applicable rules and fee guidelines.
3. The Maximum Allowable Reimbursement is calculated as follows; (Time + Base) x Division Conversion Factor or 13 + 5 = 18 x 55.3 (2013 conversion factor) = $829.50. This amount is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $829.50.

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 $829.50 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 14, 2014 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.