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
DR. PETER E. GRAYS

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-14-1107-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
DECEMBER 17, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Texas Mutual Insurance Company has failed to process reimbursement for the processing of FORM 69, Report of Medical Evaluation performed on [Claimant] on 01/30/2013 due to the timely for filing has expired. This claim was sent in a timely manner and proof of filing has been submitted to Texas Mutual for reconsideration and we have been unsuccessful for benefit release."

Amount in Dispute: $863.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual on 6/14/13 received the bill from **PETER GRAYS MD**…Because the received date is greater than 95 days from 1/30/13 Texas Mutual declined to issue payment. **PETER GRAYS MD** argues it submitted the bill to its electronic clearing house, P2P, on 1/31/13 and supports this with a screen shot from its billing software system…Texas Mutual was not convinced by the screen shot as it is evidence only that the bill was submitted to P2P, not that P2P submitted the bill electronically to Texas Mutual and has confirmation of that. The rationale given by the requestor for the late bill is not persuasive. No payment is due."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 30, 2013	MMI/IR Evaluation by Treating Doctor CPT Code 99455-V5-WP	$863.00	$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. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.

4. 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.

Issues

Did the requestor timely file the medical bill per Section 408.027(a)?

Findings

According to the explanation of benefits, the respondent denied reimbursement for the disputed Designated Doctor Evaluation based upon reason code "CAC-29."

- Texas Labor Code §408.027(a) states "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.'
- 28 Texas Administrative Code §102.4(h), states "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."

The Division considered the parties positions and reviewed the submitted documentation and finds that the requestor submitted a copy of a computer screen that indicates that an electronic copy was sent on January 31, 2013. The computer screen does not support that the claim was sent to the respondent. No other communication evidence referenced in 28 Texas Administrative Code §102.4(h) was submitted to support the requestor's position. The Division concludes that the requestor did not support position that claim was billed timely in accordance with Texas Labor Code §408.027(a). As a result, no reimbursement is recommended.

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 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

Signature	Medical Fee Dispute Resolution Officer	11/13/2014 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.