



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

ST MARY BEHAVIORAL PAIN
MANAGEMENT

Respondent Name

HARTFORD FIRE INSURANCE CO

MFDR Tracking Number

M4-15-1226-01

Carrier's Austin Representative Box

Box Number 47

MFDR Date Received

December 19, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are requesting assistance from your office on the above-mentioned patient for services rendered on 4/9/14 and 4/24/14. Services were denied for the following reason(s);

- W1 – Workers' Compensation jurisdictional fee schedule adjustment.
- The time limit for filing has expired.

This denial is invalid as the fee schedule is not \$0.00 and the original bill was submitted on 5/16/14 for dates of service 4/9/14 and 4/24/14. These services were pre-authorized, deemed reasonable and necessary and therefore should be reimbursed properly. Reconsideration was submitted on 10/9/14 and again on 11/11/14 for dates of service 4/9/14 and 4/24/14."

Amount in Dispute: \$355.72

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We are in receipt of the medical fee dispute resolution request from St. Marys Behavioral Pain Management for dates of service 4/9/14-4/24/14. We have checked our records and do not find receipt of the bills in question, therefore we maintain our position that the bills were not timely submitted."

Response Submitted by: BROADSPIRE

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 9, 2014 and April 24, 2014	CPT Code 90834	\$355.72	\$ 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:
 - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline
 - D10 – The time limit for filing has expired
 - P12 – Workers’ Compensation Jurisdictional Fee Schedule Adjustment
 - 18 – Exact duplicate claim/service
 - 224 – Duplicate charge
 - P13 – Payment reduced or denied on Workers’ Compensation Jurisdictional Regulations or payment policies. Use only if no other code is applicable

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 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	Date
		4/10/15

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

Health care providers may verify workers' compensation insurance coverage and contact information from our website at www.tdi.texas.gov/wc/employer/coverage.html or for additional assistance call the TDI-DWC Insurance Coverage section at **800-372-7713**.