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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS HEALTH DBA INJURY 1 OF DALLAS

Respondent Name
HANOVER INSURANCE CO

MFDR Tracking Number
M4-16-2737-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
May 10, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim was originally mailed on 07/17/15, faxed on 09/16/15 (per the attached fax confirmation), and re-faxed on 12/17/15 (per the attached fax confirmation). Please see attached for further review."

Amount in Dispute: $202.05

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Research has shown that the billing in question was not received by the respondent through paper mailing or electronic transmission until December 17, 2015. The requestor has not provided support that the original billing was mailed timey. The fax number of 508-926-5176 used by the requestor has not been in service with the any employee at the respondent since April 2015, well before the claimed September 2015 faxed date. The first notice regarding charges for this date of Service of July 17, 2015 was received December 17, 2015, therefore past the 95 day filing limit."

Response Submitted by: Allmerica Financial Benefit Company

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
July 17, 2015	90837	$202.05	$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.

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. The requestor seeks reimbursement for CPT Code 90837 rendered on July 17, 2015. Review of the submitted documentation finds that the requester faxed the bill to the insurance carrier on September 16, 2015 to fax number 508-926-5176 and on December 17, 2015 to fax number 508-926-5660. The insurance documents that fax number 508-926-5176 has not been in service since April 2015 prior to the requester fax date of September 16, 2015. Respondent also indicated that the bill was not received until December 17, 2015 when the requester faxed the bill to fax number 508-926-5660.

   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." The requester submitted insufficient documentation 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 insufficient 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	Medical Fee Dispute Resolution Officer	May 26, 2016 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