TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
EVERGREEN SPINE & NEUROSURGERY CENTER
CYRIL T. SEBASTIAN, MD

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-19-1041-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
OCTOBER 23, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Below is an outline of the timeline of my attempts to have the claims below made payable by Texas Mutual Insurance Company and Adjuster Dominique Wilson…We filed one claim for DOS 2/5/2018…and four claims for DOS 2/6/2018…All five paper claims were mailed…on April 11, 2018…We received payment on two of the five claims mailed on April 11, 2018…in the form of screen shots obtained from my EHR system showing that the paid claims and the non-paid claims were mailed on the same day."

Amount in Dispute: $76,849.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requester argues that since some billing was received by Texas Mutual and paid then all the billing submitted the same date should be paid. Texas Mutual, though, has no record of receiving the billing listed in the Tables of Disputed Services. Although the requester provided printouts stating 'Sent to Payer' it does not necessary follow that 'Sent to Payer' means received by the payor. It may mean the billing was sent to the requester's electronic clearing house and then went no further. It is just unknown and the printouts do not clarify that. For these reasons Texas Mutual maintains its denial of payment."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 5, 2018	CPT Code 99284	$1,162.20	$0.00
February 6, 2018	CPT Code 63087-62	$23,905.50	$0.00
	CPT Code 22854-62	$3,361.70	$0.00

	CPT Code 22556-62	$16,495.70	$0.00
	CPT Code 22585-62	$3,278.80	$0.00
February 6, 2018	CPT Code 20930	$1,002.97	$0.00
	CPT Code 22610	$13,238.30	$0.00
	CPT Code 22614	$4,135.20	$0.00
	CPT Code 22840	$8,026.90	$0.00
	CPT Code 20936	$1,238.96	$0.00
	CPT Code 20930	$1,002.97	$0.00
Total		$76,849.20	$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 §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
3. 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(B) provider shall not submit a medical bill later than the 95th day after the date the service.
   - CAC-W3, 350-IN accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
   - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 891-No additional payment after reconsideration.
   - 4271-Per TX Labor Code Sec. 413.016, providers must submit bills to payors within 95 days of the date of service.

Issues

Did the requestor support position that the disputed bills were submitted timely?

Findings

According to the explanation of benefits, the respondent denied reimbursement for the services in dispute based upon reason codes "CAC29-The time limit for filing has expired," and "731-Per 133.20(B) provider shall not submit a medical bill later than the 95th day after the date the service." The respondent contends that reimbursement is not due because "Texas Mutual, though, has no record of receiving the billing listed in the Tables of Disputed Services. Although the requester provided printouts stating 'Sent to Payer' it does not necessary follow that 'Sent to Payer' means received by the payor. It may mean the billing was sent to the requester's electronic clearing house and then went no further. It is just unknown and the printouts do not clarify that. For these reasons Texas Mutual maintains its denial of payment."

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 requestor submitted a computer printout report that indicates bills were "SENT TO PAYER" on "04/11/2018". A review of the submitted documentation does not contain any evidence such as a fax, personal delivery, electronic transmission, or certified green card to support the disputed bill was sent to the respondent on April 11, 2018.

The division finds that the requestor has not sufficiently supported that the disputed bill were sent timely to the respondent in accordance with Texas Labor Code §408.027(a). As a result, reimbursement is not 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

		11/15/2018
Signature	Medical Fee Dispute Resolution Officer	Date
		11/15/2018
Signature	Director of Medical Fee Dispute Resolution	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.