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. JOHN F. GARVISH

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-12-2249-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
FEBRUARY 28, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are writing in reference to [Claimant] and the denial of his claim for past the filing deadline. At the time of the patient's services we were unaware of this service being covered under Workers Compensation."

Amount in Dispute: $36.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor provided professional radiology services on 9/1/11 then submitted a complete bill to Texas Mutual for this on 12/14/11. (Attachment) Ninety-five days from 9/1/11 is 12/5/11. The reasons provided by the requestor for the late billing are not amount the exception criteria for late bills given in the Labor Code at 408.0272. No payment is due."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 1, 2011	CPT Code 71020-26-76 Chest X-Ray	$36.00	$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. Texas Labor Code §408.0272, effective September 1, 2007, provides for exceptions for timely submission of a claim by a health care provider.
3. 28 Texas Administrative Code §133.307, effective May 25, 2008, 33 *Texas Register* 3954, sets out the procedures for resolving a medical fee dispute.
4. 28 Texas Administrative Code §133.20, effective January 29, 2009, 34 *Texas Register* 430, sets out the procedure for healthcare providers submitting medical bills.

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.
   - CAC-18-Duplicate claim/service.
   - 18-Duplicate charge.
   - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 724-No additional payment after a reconsideration of services.
   - 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

1. Did the requestor support that disputed bill was submitted timely?
2. Does the disputed bill meet exception for filing timely? Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the disputed chest x-ray 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.'

   The disputed date of service is September 1, 2011. A review of the submitted documentation indicates that the requestor sent the medical bill on December 14, 2011. The Division finds that December 14, 2011 is past the 95 day deadline established in Texas Labor Code §408.027(a). The Division concludes that the disputed medical bill was not sent timely.

2. Texas Labor Code §408.0272(b)(1) states "Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if: (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with: (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured; (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title."

   The requestor states that "…the patient was in a motor vehicle accident and the hospital had him as self pay on his paper work. Therefore we billed the patient accordingly and our office mailed out three statements to the patient." In support of their position, the requestor submitted statements dated September 16, 2011, October 14, 2011, and November 18, 2011 to the injured worker.

   Billing the injured worker is not an exception to timely filing outlined in Texas Labor Code §408.0272(b)(1). As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional 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

		07/22/2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.