



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Novamed Surgery Center of Tyler

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-25-2495-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

October 29, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 16, 2024	63685,63650,63650-76	\$63,434.75	\$0.00
February 16, 2024	01942	\$1000.00	\$0.00
Total		\$64,434.75	\$0.00

Requestor's Position

"We would like to present a copy of the successful fax transmission that was submitted on 02/28/24 to fax number: 512-224-3889. It details that your office received 12pages. We included a copy of the claim, medical records, and other documents that will support the billing".

Amount in Dispute: \$64,434.75

Respondent's Position

"Texas Mutual has reviewed the DWC -60 submitted by NOVAMED SURGERY CENTER OF TYLER. Texas Mutual on 02/28/2024 received an incomplete bill from NOVAMED SURGERY CENT OF TYLER INC. Texas Mutual returned the bill to NOVAMED SURGERY CENTER OF TYLER INC with an explanation regarding the requirement for submitting a complete bill and notification of timely filing requirement. Texas Mutual on 8/13/2024 received a complete fill from NOVAMED SURGER CENTER OF TYLER INC. Our position is that no payment is due."

Response Submitted by: Texas Mutual

Findings and Decision

Authority

This medical fee dispute is decided according to [Texas Labor Code §413.031](#) and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. [28 Texas Administrative Code \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §133.20](#) sets out requirements of medical bill submission.
3. [28 TAC §102.4](#) details the general rules for Non-Division Communication.
4. [Texas Labor Code 408.0272](#) sets out the workers compensation timely billing and exceptions guidelines.

Denial Reasons

The insurance carrier denied the disputed services with the following claim adjustment codes.

- CAC-W3 – 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.
- CAC-29 – The time limit for filing has expired.

Issues

1. Did the requestor support timely submission of medical claim?

Findings

1. The requestor is seeking reimbursement of surgical services rendered in February of 2024. The insurance carrier denied the service as not submitted within 95 days of the date of service. DWC Rule 28 TAC §102.4 (h) Unless the great weight of evidence indicates otherwise, written communications will 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 through 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 must be the next previous day that is not a Sunday or legal holiday.

DWC Rule 28 TAC §133.20 (b) states in pertinent part,

(b) Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.

Texas Labor Code 408.0272. (b) states in pertinent part,

(b) Notwithstanding Section 408.0272, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.0272(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;

(2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

Review of the submitted documentation found notification from Texas Mutual of the "Return" of the medical bill as the physical address where the medical services were rendered in box 32 was incomplete.

DWC finds insufficient evidence to support that the claim was corrected and resubmitted with 95 days and there is insufficient information to support an exception described above. No payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to \$0.00 additional reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

November 18, 2024

Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in [28 TAC §141.1\(d\)](#).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico CompConnection@tdi.texas.gov.