Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address Med-Center Emergency Physician, P.A. P.O. Box 4590, Dept. 6 Houston, TX 77210	MFDR Tracking No.: M4-07-0305-01 DWC Claim No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 28 Liberty Mutual Insurance Co.	Date of Injury: Employer's Name: Hibernia Corp. Insurance Carrier's No.: WC9733453406SUS

PART II: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part III Reference
12-5-05	12001 64450 99283	1-4

PART III: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Texas Labor Code 413.011(a-d) titled *Reimbursement Policies and Guidelines* and Division Rule 134.202 titled *Medical Fee Guideline*, effective August 1, 2003, sets out reimbursement guidelines. The Division will resolve medical fee disputes according to Rules 133.305, 133.307, 134.801 (c)(2) and other rules.

1. This dispute relates to procedures/services that were billed under CPT codes 12001, 64450 and 99283 that were denied reimbursement by the insurance carrier based upon "F286 – Date(s) of service exceed (95) day time period for submission per Rule 408.027 and Bulletin No. B-0037-05A."

2. Rule 102.4(h), titled General Rules for Non-Commission Communication, 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."

3. Section 408.027(a) of the Labor Code 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."

4. The Requestor did not submit convincing evidence to support position that CMS-1500 was submitted timely to the Respondent per Section 408.027(a).

PART IV: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 402.00128(b)(7)
Texas Labor Code 408.027(a)
28 Texas Administrative Code Sec. §102.4(h)
28 Texas Administrative Code Sec. §133.305
28 Texas Administrative Code Sec. §133.307
28 Texas Administrative Code Sec. §134.801

PART V: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031 and 408.027(a), the Division has determined that the request was not timely filed and the requestor has forfeited the right to reimbursement.

Decision by:

	Elizabeth Pickle, RHIA	April 25, 2007
Authorized Signature	Medical Fee Dispute Resolution Officer	Date of Decision

PART VI: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

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