



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
MedCenter Emergency Physician, PA
P.O. Box 4590, Dept. 06
Houston, TX 77210

MFDR Tracking No.: M4-07-0467-01

DWC Claim No.:

Injured Employee's Name:

Respondent's Name and Address BOX #: 54
Texas Mutual Insurance Co.

Date of Injury:

Employer's Name: RCS Pizza LLC

Insurance Carrier's No.: 85006399269

PART II: SUMMARY OF DISPUTE AND FINDINGS

| Date(s) of Service | CPT Code(s) or Description | Part III Reference |
|--------------------|----------------------------|--------------------|
| 2-20-06 | 12001 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 and 99283 that were denied reimbursement by the insurance carrier based upon "This bill has exceeded the maximum time allotted for submission (Rule 134.801(c) or Rule 133.20) to the carrier; please provide proof of timely filing if applicable."
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 413.011(a-d)
Texas Labor Code 408.027(a)
28 Texas Administrative Code Sec. §134.1
28 Texas Administrative Code Sec. §134.202
28 Texas Administrative Code Sec. §102.4(h)

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.