

**Texas Department of Insurance, Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION****PART I: GENERAL INFORMATION**

Requestor's Name and Address:

Oaks Medical Center  
25410 I 45 N  
Spring, TX 77386

MFDR Tracking #: M4-08-2424-01

DWC Claim #:

Injured Employee:

Date of Injury:

Respondent Name and Box #:

Dolgencorp Of Texas Inc.  
Rep Box # 19

Employer Name:

Insurance Carrier #:

**PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION**

Requestor's Position Summary taken from the Table of Disputed Services: "Claim was filed in a timely fashion."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought – \$210.00
3. CMS 1500s
4. EOBs

**PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION**

Respondent's Position Summary: "The provider has filed a request for medical dispute resolution concerning a service date of March 5, 2007. The provider attached a copy of the carrier's EOB dated November 16, 2007, which is the second EOB filed by the carrier. I am enclosing a copy of the carrier's initial EOB, which is dated October 17, 2007. That EOB indicates that the carrier initially received the provider's CMS-1500 on October 10, 2007. The carrier denied the CMS-1500 on the basis that the provider did not timely file the CMS-1500."

Principle Documentation: 1. DWC-60 Response

**PART IV: SUMMARY OF FINDINGS**

Eligible Date(s) of Service (DOS)	CPT Code(s) and Calculation(s)	Denial Code(s)	Part V Reference	Amount Ordered
03/05/2007	99203,73130,99080-73	18,277, 16,270	1-3	Reimburse per Rule 134.202
<b>Total Due:</b>				Reimbursement per Rule 134.202

**PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION**

Texas Labor Code 402.00128(b)(7) titled *General Powers and Duties of Commissioner* authorizes the Commissioner to enter appropriate orders. The Division will resolve medical fee disputes according to Rules 133.305, 133.307, 133.20(b), 133.200, 133.240 and other rules.

1. This dispute relates to procedures/services billed with CPT Codes 99203, 73130, 99080-73 rendered on 03/05/2007 that were denied reimbursement by the insurance carrier based upon denial reason "18-Duplicate claim/service", "277-These services/charges have been previously reviewed and allowance recommended on another analysis. Returned as a duplicate bill", "16-Claim/Service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate", "270-\*No allowance has been recommended for this procedure/service/supply. 270-TDI Title 28 Chapter 134.801 providers only have 95 days to submit medical bills for payment from the date of service."
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."
1. 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." The Requestor submitted documentation to support services were rendered as billed. The Respondent submitted an EOB dated 03/19/2007 verifying this was not a duplicate bill.
  2. Per review of Box 32 on CMS-1500, zip code 77386 is located in Montgomery County. The maximum reimbursement amount, under Rule 134.202(c) (1), is determined by locality.
3. The Requestor provided written documentation to the Division supporting the medical bill was submitted timely to the carrier. The health care provider submitted a CMS-1500, dated 03/19/2007 in block # 31. (The DWC-67, instructions for completing the CMS-1500 directs the health care provider to notate in block 31 the date the claim is submitted to the carrier.) The medical bill was timely submitted.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES**

Texas Labor Code 402.00128(b)(7)	
Texas Labor Code 408.027(a)	28 Texas Administrative Code Sec. 134.202
Texas Labor Code Sec. §413.031 and §413.0311	28 Texas Administrative Code Sec. 133.20(b)(effective 5/2/06)
28 Texas Administrative Code Sec. §102.4(h)	28 Texas Administrative Code Sec. 133.2
28 Texas Administrative Code Sec. §133.305	28 Texas Administrative Code Sec. 133.240
28 Texas Administrative Code Sec. §133.307	
28 Texas Administrative Code Sec. §134.801(effective 9/1/05)	
Subchapter G, Chapter 2001, Texas Government Code	

**PART VII: DIVISION DECISION**

The Division hereby orders the Respondent to reimburse the Requestor in accordance with Rule 134.202 plus interest per Division Rule 134.130, for services included in the original bill(s) within 30 days of receiving this Order.

**ORDER:**

_____	_____	02/13/2008
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

#### **PART VIII: YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (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. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.0311.

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