



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

FILI TALAMANTEZ DC

Respondent Name

BRADFORD HOLDING COMPANY INC

MFDR Tracking Number

M4-15-1612-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

January 29, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement received from the requestor.

Amount in Dispute: \$650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Original bill received on December 2, 2014.

Position statement: [employer], is a certified self insured for workers compensation. Therefore the carrier is Bradford Holding Co. The insured employer is both [employer]. The carrier first received the bill for DOS 2/14/14 by Dr. Fili Talamantez on 12/2/14. The bill was not received within 95 days of the date of service and was properly denied for lack of timely filing. Please note the bill for this service shows the billed entity as [employer], the insured, and the bill was sent to their address, 4705 Towerwood Dr. Brownsville, Texas 78521. In the providers position statement that accompanied their appeal to MFDR, the provider acknowledges the faxed the bill to the insured on 5/15/14. The date in Block 31 on the only copy of the bill provided by the provider is 5/15/14. The provider has furnished no evidence the bill was submitted to the carrier prior to 12/2/14."

Response Submitted by: Risk Management Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 14, 2014	CPT Code 99456-WP	\$650.00	\$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. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.

4. Texas Labor Code §408.027 sets out the rules for timely submission of claims by health care providers.
5. Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical bill.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 29 – The time limit for filing has expired
 - 937 – Service(s) are denied based on HB7 provider timely filing requirement. A provider must submit a medical bill to the insurance carrier on or before the 95th day after the date of service
 - W3 – Additional payment made on appeal/reconsideration
 - 194 – Claim/service adjusted because the attachment referenced on the claim was not received in a timely fashion
 - 193 – Original payment decision is being maintained. This claim was processed properly the first time
 - 937 – Service(s) are denied based on HB7 provider timely filing requirement. A provider must submit a medical bill to the insurance carrier on or before the 95th day after the date of service

Issues

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. 28 Texas Administrative Code §133.20(b) requires that, except as provided in Texas Labor Code §408.0272, “a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.” No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided.
2. Texas Labor Code §408.027(a) states, in pertinent part, that “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.” 28 Texas Administrative Code §102.4(h) states that “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.” Review of the submitted information finds no documentation to support that a medical bill was submitted within 95 days from the date the services were provided. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor has forfeited the right to reimbursement due to untimely submission of the medical bill for the disputed services.”

Conclusion

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

Signature	Medical Fee Dispute Resolution Officer	4/3/15 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).

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

Health care providers may verify workers' compensation insurance coverage and contact information from our website at www.tdi.texas.gov/wc/employer/coverage.html or for additional assistance call the TDI-DWC Insurance Coverage section at **800-372-7713**.