



**TEXAS DEPARTMENT OF INSURANCE**

**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**  
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**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

**GENERAL INFORMATION**

**Requestor Name**

PAIN AND RECOVERY CLINIC

**Respondent Name**

CITY OF HOUSTON

**MFDR Tracking Number**

M4-16-0949-01

**Carrier's Austin Representative**

Box Number 29

**MFDR Date Received**

DECEMBER 11, 2015

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Our facility has been having difficulties with the above carrier in processing these authorized services which were denied for fee schedule adjustments."

**Amount in Dispute:** \$170.84

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Based on the submitted documentation no additional payment is being made at this time. In regards to 28 Texas Administrative Code §102.4(h), accepted proof of timely filing was not submitted."

**Response Submitted by:** Injury Management Organization, Inc.

**SUMMARY OF FINDINGS**

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|------------------|-------------------|-------------------|------------|
| June 22, 2015    | CPT Code 97140-GP | \$95.46           | \$0.00     |
|                  | CPT Code 97112-GP | \$53.38           | \$0.00     |
|                  | CPT Code G0283    | \$22.00           | \$0.00     |
| TOTAL            |                   | \$170.84          | \$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. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
2. 28 Texas Administrative Code §133.20, effective January 29, 2009, sets out the procedure for healthcare providers submitting medical bills.

3. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
4. The services in dispute were reduced / denied by the respondent with the following reason codes:
  - 29-The time limit for filing has expired.

**Issues**

Did the requestor support position that the disputed bills were submitted timely? Is the requestor entitled to reimbursement?

**Findings**

1. According to the explanation of benefits, the respondent denied reimbursement for the services in dispute based upon reason code “29-The time limit for filing has expired.”

Texas Labor Code §408.027(a) 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.”

28 Texas Administrative Code §102.4(h), 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.” A review of the submitted documentation does not contain any evidence such as a fax, personal delivery, electronic transmission, or certified green card to support the disputed bill was sent to the respondent within the 95 days deadline.

The Division finds that the requestor did not sufficiently support it’s position that the disputed bill was submitted timely in accordance with Texas Labor Code §408.027(a). As a result, reimbursement is not recommended.

**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

12/30/2015  
\_\_\_\_\_  
Date

## **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.**