



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

Orthopaedic Associates of Central Texas

Respondent Name

Travis County

MFDR Tracking Number

M4-16-1954-01

Carrier's Austin Representative

Box Number 38

MFDR Date Received

March 9, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claims were sent out certified mail and were signed by a York Agent within a timely filing frame. They continue to deny our attempts for remittance."

Amount in Dispute: \$2,395.31

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged, received on March 14, 2016. The insurance carrier did not submit a response for consideration in this review. Per the Division's former rule at 28 Texas Administrative Code §133.307(d)(1), "If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information." Accordingly, this decision is based on the available information.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 25, 2015	99203, 73030, 99080	\$2,395.31	\$1,160.11
August 28, 2015	73222, 77002, A9579, 23350		
September 1, 2015	99214, 99080		

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.

3. 28 Texas Administrative Code §102.4 establishes rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
5. Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical claim.
6. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
7. 28 Texas Administrative Code §129.5 sets out the reimbursement guidelines for work status reports.
8. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 29 – The time limit for filing has expired

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?
3. What is the rule applicable to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied the disputed services with claim adjustment reason codes: 29 – “The time limit for filing has expired.” 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.” Review of the submitted documentation finds evidence to support timely submission of the services in dispute.
2. Texas Labor Code §408.027(a) states 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 the following documentation included with this dispute;

- Certified Mail receipt, 7014 0150 0001 8151 3241 showing date of delivery September 25, 2015.
- Memo from account of claimant that states, “9/22/2015 – WC claim mailed certified # 7014 0150 0001 8151 3241.”

Pursuant to the above the Division finds the requestor has not forfeited their right to reimbursement for the services in dispute. Dates of service August 25, 2015, August 28, 2015 and September 1, 2015 will be reviewed per applicable rules and fee guidelines.

3. The dates of service in dispute are related to professional medical services. Texas Administrative Code 134.203 states in pertinent part, “

The maximum allowable reimbursement is calculated as follows:

Date of Service	Submitted Code	Submitted Charge	Allowable	Maximum Allowable Reimbursement = (DWC Conversion Factor / Medicare Conversion Factor) x Allowable = TX Fee MAR
August 25, 2015	99203	\$312.00	\$104.38	35.9335/56.2 x \$104.38 = \$163.25
August 25, 2015	73030	\$81.27	\$27.19	35.9335/56.2 x \$27.19 = \$42.52
August 25, 2015	99080 -73	\$15.00	\$15.00	RULE §129.5(3)(i) Notwithstanding any other

				provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. <i>The amount of reimbursement shall be \$15.</i>
August 28, 2015	73222 -TC	\$1060.26	\$274.02	$35.9335/56.2 \times \$274.02 = \428.57
August 28, 2015	77002	\$223.17	\$87.03	$35.9335/56.2 \times \$87.03 = \136.11
August 28, 2015	A9579	\$5.00	n/a	Status Code X – Statutory Exclusion
August 28, 2015	23350	\$374.25	\$125.83	$35.9335/56.2 \times \$125.83 = \196.80
September 1, 2015	99214	\$309.36	\$104.13	$35.9335/56.2 \times \$104.13 \times \162.86
September 1, 2015	99080 -73	\$15.00	\$15.00	RULE §129.5(3)(i) Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be \$15.
			Total	\$1,160.11

4. The total allowable reimbursement for the services in dispute is \$1,160.11. The carrier previously paid \$0.00. The remaining balance of \$1,160.11 is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$1,160.11.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$1,160.11 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

Date

May , 2016

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 MFDR 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.