



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

PATIENT CARE INJURY CLINIC
JOHN TAYLOR, DC

Respondent Name

FEDERAL INSURANCE CO

MFDR Tracking Number

M4-16-2417-01

Carrier's Austin Representative

Box Number 17

MFDR Date Received

APRIL 12, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After requesting reconsideration in a timely fashion VIA mail to Chubb, it is quite evident that the carrier is unwilling to reimburse our facility for medical bills that were authorized. We feel that our facility should be paid according to the fee schedule guidelines, I have provided a screen shot of my billing system to show proof of timely filing."

Amount in Dispute: \$1,132.32

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent received the medical bills for dates of service 7/2/15 through 7/8/15 on 1/20/16. Please see the attached date-stamped medical bills. This was the first receipt of the bills. They were then properly denied for lack of timely filing as they were received more than 95 days after the date of service. Therefore, no reimbursement is owed to Requestor."

Response Submitted By: Downs Stanford, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 2, 2015 Through July 8, 2015	Physical Therapy Services	\$1,132.32	\$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 code:
- 29-The time limit for filing claim/bill has expired.

Issues

Did the requestor support position that the disputed bills were submitted timely?

Findings

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 claim/bill 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."

To determine when the bills were sent, the Division reviewed the submitted documentation and finds that the requestor did not submit a fax, personal delivery or electronic transmission or a postmark letter to support that the disputed bills were 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 additional 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

05/05/2016

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.