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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
OCCUPATIONAL MEDICAL CARE PASADENA

Respondent Name
UNIVERSITY OF TEXAS SYSTEM

MFDR Tracking Number
M4-19-0959-01

Carrier's Austin Representative
Box Number 46

MFDR Date Received
OCTOBER 18, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary in the dispute packet.

Amount in Dispute: $561.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the submitted documentation from the provider using a printout referring to electronic submission of a bill we find that in the providers documentation the electronic submission failed and was rejected three times on 3/19/18 9:42, 3/19/18 9:43 and again on 4/19/18 at 9:48 and not successfully submitted to the carrier. The bills were then not resubmitted by the provider until 7/30/18 and again on 9/14/18 by fax which put them out of the billing time frame requirements under 28 TAC §§**133.20. Medical Bill Submission by Health Care Provider**."

Response Submitted by: Injury Management Organization (IMO)

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 25, 2018 February 5, 2018 March 14, 2018	CPT Code 99214	$172.10/ea	$0.00
	CPT Code 99080	$15.00/ea	$0.00
Total		$561.30	$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 §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
3. The services in dispute were reduced / denied by the respondent with the following reason codes:
   - 29-The time limit for filing has expired.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
   - 4271-Per TX Labor Code Sec. 413.016, providers must submit bills to payors within 95 days of the date of service.

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 has expired." The respondent contends that reimbursement is not due because "the electronic submission failed and was rejected three times on 3/19/18 9:42, 3/19/18 9:43 and again on 4/19/18 at 9:48 and not successfully submitted to the carrier."

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."

The division reviewed the following submitted documentation:

- The requestor submitted a report from JOPARI Solutions, Inc. that indicates for dates of service 01/25/2018, 02/05/2018, and 03/14/2018 "the file was forwarded to payer on 03/12/2018". The division finds this report does not support bill was submitted to the respondent because 03/12/2018 is prior to date of service 03/14/2018.
- The requestor did not submit a bill for date of service 03/14/2018.
- The submitted bills are stamped at the top header with information that indicates for date of service 01/25/2018 and 02/05/2018 the received date of "20180312". The corresponding reports indicate that on this date, "Claim was accepted and forwarded to another clearing house." Followed by another entry dated 03/19/2018 "Claim was externally rejected".

The division finds that the requestor has not sufficiently supported that bill was sent timely to the respondent.

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

		11/15/2018
Signature	Medical Fee Dispute Resolution Officer	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.