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
Orthotexas Physicians and Surgeon

Respondent Name
Travelers Indemnity Co

MFDR Tracking Number
M4-19-1692-01

Carrier's Austin Representative
Box 5

MFDR Date Received
November 20,2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the centricity report DOS 5/23/18 was transmitted on 5/30/18 to Travelers. All of these dates are within the 95 day filing deadline even though this was sent to the wrong carrier. See the attached proof of timely report from Centricity."

Amount in Dispute: $782.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider contends they timely submitted the billing for the disputed services on 05-30-2018. In support, of that contention, they submit a screen shot of their electronic billing software."

Response submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 23, 2018	Professional medical services	$782.00	$0.00

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

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 requirements of medical bill submission.
3. Texas Labor Code 408.0272 sets out the workers compensation timely billing and exceptions guidelines.
4. 28 Texas Administrative Code §102.4 sets out general guidelines for non-commission communications.
5. 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. Is the requestor's position statement supported?

Findings

1. The requestor is seeking $782 for professional medical services rendered on May 23, 2018. The insurance carrier denied disputed services with claim adjustment reason code 29 – "The time limit for filing has expired." The requestor states, "Per the centricity report DOS 5/23/18 was transmitted on 5/30/18 to Travelers. All of these dates are within the 95 day filing deadline even though this was sent to the wrong carrier…"

   28 TAC §133.20 (b) states in pertinent part,

   > (b) Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill.

   28 TAC §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.

Review of the submitted documentation found insufficient evidence to support the claim was sent to the wrong carrier or that a report showing successful transmission and acceptance of an electronic claim to the correct carrier. As the requirements of 28 TAC 102.4 (h) or 28 TAC 133.20 (b) were not met, the carrier's denial is supported. No additional payment is 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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		January 4, 2019
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 Rule §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. **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.