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
Occupational Medical Care

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-19-1744-01

Carrier's Austin Representative
Box 45

MFDR Date Received
November 26, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Bills were originally sent electronically. Please see attached documents from Japari."

Amount in Dispute: $314.24

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office reviewed the documentation submitted by the requestor in their dispute packet and while the requestor's argument was they had submitted the bills electronically within 95 days, it appears the electronic submissions were rejected by the clearinghouse for an undetermined reason."

Response submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 15, 2018 March 15, 2018	99214, 99080 99214, 99080	$314.24	$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. 28 Texas Administrative Code §102.4 sets out general guidelines for non-commission communications.
4. 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 insurance carrier's reason for denial of payment supported?

Findings

1. The requestor is seeking $314.24 for professional medical services rendered on February 15, 2018 and March 15, 2018. The insurance carrier denied disputed services with claim adjustment reason code 29 – "The time limit for filing has expired."

   28 TAC §133.20 (b) states in pertinent part, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided."

   The requestor states, "Originally set electronically within timely filing filing…" Review of the submitted documents found;

   - 837 electronic transmission report for date of service February 15, 2018
     - Bill created March 14, 2018
     - Bill sent March 15, 2018
     - Bill Rejected April 30, 2018
   - 837 electronic transmission report for date of service March 15, 2018
     - Bill created April 10, 2018
     - Bill sent April 13, 2018
     - Bill rejected April 19, 2018

   The submitted documents do not support the claim was successfully transmitted and received electronically. The requestor's position is not supported. No additional payment is recommended.

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 $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 24, 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.