



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

Respondent Name

Travelers Indemnity Co

MFDR Tracking Number

M4-19-3278-01

Carrier's Austin Representative

Box 5

MFDR Date Received

February 27, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claims were transmitted to WCEDI on 7/31/2018 in batch # 157887258."

Amount in Dispute: \$674.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Carrier contends the Provider has not submitted appropriate evidence of timely submission of the billing in dispute."

Response submitted by: Travelers

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: July 11, 2018, 73110, 73560, L1833, 99080, \$674.00, \$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. 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. Are the insurance carrier’s reasons for denial or reduction of payment supported?

Findings

- 1. The requestor is seeking \$674.00. 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,

(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.

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.

The requestor states, “The claims were transmitted to WCEDI on 7/31/2018...” Insufficient evidence was found within submitted documentation to support this position. The Division was unable to determine any exception to the timely filing requirement. The carrier’s denial is supported.

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

Signature

Medical Fee Dispute Resolution Officer

March 20, 2019
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.