



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

ORTHOTEXAS PHYSICIANS AND SURGEONS, PLLC

Respondent Name

TRAVELERS INDEMNITY CO

MFDR Tracking Number

M4-19-3938-01

Carrier's Austin Representative

Box Number 05

MFDR Date Received

APRIL 26, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Availity RCM Client, Ortho Texas Physician & Surgeons, PLLC, sent a number of Works compensation claims out on 7/31/2018, some of which have rejected for timely filing limits. We have researched and confirmed that we, Availity RCM, received and transmitted the claims to our WC Vendor on July 31st 2018 and received a valid response, via a 999 file, which indicated that the file containing these claims had been received and accepted at WCEDI. Do to our findings we reached out and worked with WCEDI to get more details on the issue.

Per our WC vendors review they confirmed that they did receive the file on 7/31/2018, however their system only processed the first 71 claims in the batch. After review, WCEDI found that the file contained a quotation mark on one of the claims which caused their system to stop processing the file at the position of the quotation. Unfortunately there were no rejections, failure reports or notices sent back to Availity RCM for the client. Per WCEDI, they have now added additional logging on their side to point this out to their support team when it occurs so it can be reported to Availity and the providers if it ever were to occur again."

Amount in Dispute: \$190.00

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. The Carrier received the initial billing for this date of service by the Provider on 12-31-2018 via fax as documented by the fax confirmation in the Provider's documentation. Based on Rule 102.4, the received date is 12-31-2018. As the submission date is 159 days after the date of service of 07-25-2018, the billing was not timely submitted as required by Rule 133.20."

Response Submitted by: William E. Weldon, Atty for Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 25, 2018	CPT Code 99080	\$15.00	\$0.00
	CPT Code 99213	\$175.00	\$0.00
TOTAL		\$190.00	\$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. 28 Texas Administrative Code §133.307, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
3. Texas Labor Code §408.0272, effective September 1, 2007, provides for exceptions for timely submission of a claim by a health care provider.
4. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
5. 28 Texas Administrative Code §133.20, effective January 29, 2009, sets out the health care providers billing procedures.
6. The services in dispute were reduced / denied by the respondent with the following claim adjustment reason codes:
 - 29-The time limit for filing has expired.
 - W3-Additional payment made on appeal/reconsideration.
 - 4271-Per TX Labor Code Sec. 413.016, providers must submit bills to payors within 95 days for the date of service.

Issues

Does the documentation support requestor's position that the disputed bills were submitted timely?

Findings

1. The requestor is seeking payment of \$190.00 for an office visit and report rendered July 25, 2018.
2. According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon reason code "29-The time limit for filing has expired."
3. To determine if the chronic pain management services are eligible for reimbursement the division refers to the following statute:
 - 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 §133.20(B) states, “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. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied. The medical bill submitted by the health care provider to the correct workers' compensation insurance carrier is subject to the billing, review, and dispute processes established by Chapter 133, including §133.307(c)(2)(A) - (H) of this title (relating to MDR of Fee Disputes), which establishes the generally acceptable standards for documentation.”
 - 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.”
4. Both parties to this dispute submitted documentation for consideration in support of their position. The division reviewed the documentation and finds
- The requestor submitted a fax confirmation report that supports a claim was submitted to respondent on December 31, 2018.
 - The date of service in dispute is July 25, 2018.
 - The requestor did not sufficiently support that the claim was submitted to the respondent within the 95 day deadline set out in Texas Labor Code §408.027(a) and 28 Texas Administrative Code §133.20(B).
 - The respondent’s denial of payment based upon timely filing is supported.

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

Signature

Medical Fee Dispute Resolution Officer

05/24/2019
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 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.