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
TEXAS ORTHOPEDIC HOSPITAL

Respondent Name
TRAVELERS INDEMNITY CO OF AMERICA

MFDR Tracking Number
M4-21-0956-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
February 11, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are in receipt of a denial for timely filing Travelers Insurance date 4/15/2020. We set the required information to Travelers Insurance and they denied the appeals. We are requesting this claim be adjusted with the attached proof showing the circumstance's of the billing and acknowledgment of receipt of claim on 10/25/2019. Therefore the claim was denied in a Timely manner. For this reason, alone, we are submitting this claim to you for review and processing. Note we are within your timely filing limit for 95 days for submission."

Amount in Dispute: $43,484.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider admits they did not timely file the medical billing in dispute. Consequently, the Provider is not entitled to reimbursement as they failed to timely submit a complete bill to the Carrier. The Carrier contends it received the initial complete billing for this date of service on 4-02-2020. As this date is 174 days after the date of service of 10-10-2019, the billing was not timely submitted as required by Rule 133.20. The Provider failed to timely submit the billing and has waived the right to reimbursement.

Furthermore, the Provider has waived the right to reimbursement under Rule 133.307 as they did not timely file their Request for Medical Fee Dispute Resolution with the Division within one year of the date of service as required by Rule 133.307(c)(1)."

Response Submitted by: TRAVELRS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 10, 2019	Hospital Outpatient Service	$43,484.00	$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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – The time limit for filing has expired
   - 4271 – Per TX Labor Code Sec 413.016 providers must submit bills to payors within 95 days of the date of service

Issues

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states:

   Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.

   (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

   The date of the services in dispute is October 10, 2019. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on February 11, 2021. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

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 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

[redacted]	[redacted]	March 08, 2021
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 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 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.