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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ACS Primary Care Physicians

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-13-0815-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
November 20, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…ACS was notified that this is a Workers' Compensation claim Blue Cross Blue Shield of Texas notified us of this. ACS is sending the EDI statement showing this claim was sent with in timely filing."

Amount in Dispute: $623.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office reviewed the timely filing evidence submitted in the requestor's dispute packet and out of good faith we contacted the requestor on two separate occasions trying to obtain the notification date from Blue Cross Blue Shield to the provider stating that this date of service was to treat a worker's compensation injury."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 11, 2012	Emergency Room Services	$623.00	$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 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20. sets out required procedures for medical bill submission by health care provider
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 29 – The time limit for filing has expired
   - 193 – Original payment decision is being maintained

Issues

1. Did the requestor support claim submitted within 95 days?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Labor Code §133.20(b) states in pertinent part, "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." Review of the submitted documentation finds;

    a. Document titled, "Accounts Receivable Claim Maintenance"

    This document shows a section titled "Sent" 12/19/11 and "Received" 12/19/11 however, this document does not show a time or length of transmission or any other information to support the claim was submitted electronically on this date.
2. 28 Texas Administrative Code §133.20 (c) states, "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." There was no documentation found to support the requestor had submitted to Blue Cross and Blue Shield and received notification of the Workman's Compensation.
3. Based on the requirements of Rule 133.20 not being met the Division cannot recommend additional payment.

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

		August 14, 2014
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 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.