



**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**  
ETMC FIRST PHYSICIANS

**Respondent Name**  
TEXAS MUTUAL INSURANCE CO

**MFDR Tracking Number**  
M4-18-1713-01

**Carrier's Austin Representative**  
Box Number 54

**MFDR Date Received**  
JANUARY 29, 2018

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Attached are Medical Records with Proof of Timely Filing that was sent to Texas Mutual."

**Amount in Dispute:** \$200.00

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The requestor provided a screen print from its bill processing system to support its assertion it timely submitted the bill to Texas Mutual. Texas Mutual does not agree. The screen print appears to represent when the bill was created and the bill printed. It does not provide any evidence of when the bill was submitted...The screen print does not match any of the examples and on its face the screen print cannot be equated with great of evidence. The bill is untimely. No payment is due."

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 14, 2017	Laboratory Services	\$200.00	\$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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.20 sets out the health care providers billing procedures.
- 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
- 28 Texas Administrative Code §133.250 sets out the medical bill processing and audit by insurance carriers procedures.
- Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
- 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written

documentation was sent.

7. The services in dispute were reduced / denied by the respondent with the following reason codes:

Date of service 04/14/2017:

Neither party to the dispute submitted any explanation of benefits, EOBs, for this date of service.

### **Issues**

Are the disputed services dated April 14, 2017 eligible for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307?

### **Findings**

According to the DWC-60, the requestor is seeking reimbursement for laboratory services rendered on April 14, 2017.

Whether the requestor's medical fee dispute is eligible for review relies upon whether the requestor satisfied the relevant prerequisite requirements as follows:

- 28 Texas Administrative Code §133.20( f) states " Health care providers shall not resubmit medical bills to insurance carriers after the insurance carrier has taken final action on a complete medical bill and provided an explanation of benefits except in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills)."
- 28 Texas Administrative Code §133.20(g) states " Health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier."
- 28 Texas Administrative Code §133.240(a) states "An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation."
- 28 Texas Administrative Code §133.250(d) states "A written request for reconsideration shall: (1) reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill."
- 28 Texas Administrative Code §133.307(c)(2)(J) requires the requestor to submit "a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions)."
- 28 Texas Administrative Code §133.250(i) states "If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills)."
- 28 Texas Administrative Code §133.307(c)(2) requires requests for medical fee dispute resolution to submit:
  - "(D) the date(s) of the service(s) in dispute;
  - (J) a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions);
  - (K) a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB;
  - (M) a copy of all applicable medical records related to the dates of service in dispute."

A review of the submitted documentation finds no bills, explanation of benefits, request for reconsideration or medical records to support the disputed services were rendered on April 14, 2017. The division finds that date of service April 14, 2017 is not eligible for review.

**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**

		2/22/2018
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.**