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 Health Denton

Respondent Name
Safety National Casualty Corp

MFDR Tracking Number
M4-18-4147-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 2, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…they received the initial bill several times and "dropped" or returned the bills."

Amount in Dispute: $15,019.21

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor, Texas Health of Denton did not provide proof of timely filing as required by division rule."

Response Submitted by: Corvel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 13 – 18, 2017	Inpatient Hospital Services	$15,019.21	$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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – The time limit for filing claim/bill has expired

Issues

1. Was the claim submitted within Division guidelines?

Findings

1. The requestor is seeking $15,019.21 for inpatient hospital services rendered November 13 - 18, 2017. The insurance carrier denied disputed services with claim adjustment reason code 29 – "The time limit for filing has expired."

   28 Texas Administrative Code §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.

   The requestor states, "…they received the initial bill several times and "dropped" or returned the bills.

   28 Texas Administrative Code §133.20 (g) states in pertinent part,

   > Health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier.

   Review of the submitted documentation found evidence the carrier returned the original bill on December 28, 2017 as the bill was missing information. The only evidence of the carrier receiving a "new bill" as described above is an Explanation of Review that indicates the carrier received the bill on February 19, 2018. This date is past the 95 day filing deadline.

   The carrier's denial is supported. No additional payment is recommended.

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	August 2, 2018 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.