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
Texas Health HEB

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-18-4248-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
July 10, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This bill was originally billed to the patient's commercial insurance. Please see the attached commercial EOB."

Amount in Dispute: $2,220.49

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual Insurance received the bill 4/30/17[sic], well past 95 days from 8/5/17, the date on the Bluecross/Blueshield of Texas eob."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 6, 2017	Outpatient Hospital Services	$2,220.49	$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. Texas Labor Code 408.0272 sets out the workers compensation timely billing and exceptions guidelines.
4. 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 $2,220.49 for emergency outpatient services rendered on July 6, 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. 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.

   Texas Labor Code 408.0272. (b) and (c) states in pertinent part,

   > (b) Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:
   >
   > (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:
   >
   > (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;
   >
   > (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or
   >
   > (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title;
   >
   > (2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.
   >
   > (c) Notwithstanding Subsection (b), a health care provider who erroneously submits a claim for payment to an entity described by Subdivision (1) of that subsection forfeits the provider's right to reimbursement for that claim if the provider fails to submit the claim to the correct workers' compensation insurance carrier within 95 days after the date the provider is notified of the provider's erroneous submission of the claim

   Review of the submitted requestor's information did not find sufficient evidence to support that within 95 days prior to April 30, 2018 when a bill was submitted to Texas Mutual, the requestor was notified of the correct workers compensation carrier. No other exception defined in the Division Rule was found. 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

		August 2, 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 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.