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
Clinics of North Texas

Respondent Name
Wichita Falls ISD

MFDR Tracking Number
M4-19-0355-01

Carrier's Austin Representative
17

MFDR Date Received
September 21, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The original claim was sent to the employee's personal insurance Aetna on 05/07/2018 where it was paid then adjusted and refunded. Upon notification of erroneous submission it was corrected and rebilled to Claims Administrative Services on 07/25/2018. The claim denied for timely filling. I referenced the Texas Department of Insurance rule 408.0272 that states if the HCP submits a medical bill within 95 days of the DOS to the wrong insurance carrier, the HCP has 95 days from the date the provider is notified of the provider's erroneous submission of the claim."

Amount in Dispute: $757.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is our position that Clinics of North Texas had correct insurance information prior to this Date of Service, yet chose to file to an incorrect carrier. We find, that denial for timely filing should be maintained."

Response submitted by: Claims Administrative Services, Inc

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 1, 2018	73221	$757.00	$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. 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 has expired

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. The requestor is seeking $757 for Code 73221, provided on May 1,2018. The insurance carrier denied disputed services with claim adjustment reason code 29 – "The time limit for filing has expired."

   The respondent states, "…Clinics of North Texas had correct insurance information prior to this Date of Service…" Review of the submitted documentation found;

   - Office visit for date of service March 14, 2018 billed to correct worker's compensation carrier and paid
   - Office visit and CT scan for date of service March 21,2018 billed to correct worker's compensation carrier and paid

   28 TAC 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.

Based on review of the above, DWC finds the health care provider had knowledge of the correct worker's compensation carrier and the carrier's position 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	October 10, 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.