



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

East Texas Medical Center

Respondent Name

East Tx Educational Ins Assn

MFDR Tracking Number

M4-19-2372-01

Carrier's Austin Representative

Box 17

MFDR Date Received

December 27, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The initial bill and appeal were both denied for timely filing. I have attached proof that this bill was sent out on 4/10/2018."

Amount in Dispute: \$403.26

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is our position proof of timely filing has not been provided and denial should be maintained."

Response submitted by: Claims Administrative Services, Inc

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 2, 2018	73721	\$403.26	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.20 sets out requirements of medical bill submission.
- 28 Texas Administrative Code §102.4 sets out general guidelines for non-commission communications.
- 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. Is the insurance carrier’s reason for denial of payment supported?

Findings

- 1. The requestor is seeking \$403.26 for professional medical services rendered on March 2, 2018. The insurance carrier denied disputed services with claim adjustment reason code 29 – “The time limit for filing has expired.”

The requestor states, “I have attached proof that this bill was sent out on 4/10/2018.” Review of the submitted documentation found a screen shot of “AR/ADT Account Notes Inquiry.”

28 TAC §102.4 (h) states,

Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:

- (1) the date received, if sent by fax, personal delivery or electronic transmission or,
- (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.

The submitted screen shot does meet the requirements shown above. 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.

The Division found insufficient evidence to support the requestor met the 95 - day filing requirement. The insurance carriers’ denial is supported. No additional reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has 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

January 11, 2019
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.