



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

ETMC Quitman

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-19-2377-01

Carrier's Austin Representative

Box 54

MFDR Date Received

December 27, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Texas Mutual has denied this bill and appeal for timely filing. The BlueCross BlueShield Remittance is attached to prove timely filing. This bill was sent on 8/16/2018, when the worker's compensation insurance was discovered."

Amount in Dispute: \$2,024.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...the requester only submitted an EOB showing payment by BCBS. There is no notification document in the DWCO60 packet demonstrating when the requester was notified by BCBS it was the incorrect carrier. No payment is due."

Response submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 1, 2018	Outpatient hospital services	\$2,024.53	\$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.
- Texas Labor Code 408.0272 sets out the workers compensation timely billing and exceptions guidelines.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 29 – The time limit for filing has expired

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Is the insurance carrier's reason for denial of payment supported?

Findings

1. The requestor is seeking \$2,024.53 for outpatient hospital services rendered on May 1, 2018. The insurance carrier denied disputed services with claim adjustment reason code 29 – "The time limit for filing has expired."

28 TAC §133.20 (b) states in pertinent part,

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.

Review of the submitted information found insufficient evidence to support the claim was submitted to the correct workers' compensation within 95 days of notification. No additional payment 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

_____	_____	January 24, 2019
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.