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
University of Texas System

MFDR Tracking Number
M4-19-2820-01

Carrier's Austin Representative
46

MFDR Date Received
January 22, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This bill has been denied for timely filing. The BlueCross BlueShield Remittance was attached."

Amount in Dispute: $4,591.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the submitted documentation no additional payment is being made at this time. In regards to 28 Texas Administrative Code 102.4(h), acceptable proof of timely filing was not submitted."

Response submitted by: Injury Management Organization, Inc

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 25, 2018	26746 F9	$4,591.80	$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. 28 Texas Administrative Code §102.4 sets out general guidelines for non-commission communications.
5. 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 $4,591.80 for outpatient hospital services rendered on January 25, 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,

   > 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.

The health care provider states, "The BlueCross BlueShield Remittance was attached." Review of the remittance indicates a payment for the date of service in dispute. The Division finds insufficient evidence to support the timely submission of the claim to the correct workers' compensation carrier once the health care provided was made aware of the workers' compensation claim.

The insurance carriers' 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

		February 7, 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.