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**
Rio Occupational Institute

**Respondent Name**
Indemnity Insurance Co of North America

**MFDR Tracking Number**
M4-19-3077-01

**Carrier's Austin Representative**
Box number 15

**MFDR Date Received**
February 8, 2019

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "This claim was originally submitted on July 31, 2018 which is one day after the date of service."

**Amount in Dispute:** $1,1119.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The bill for date of service 7/30/18 was denied for timely filing. The fax number the provider sent the bill to be audited is not an ESIS fax number. ESIS did not receive the bill for date of service 7/30/18 until 1/2/19 when bill was mailed to the correct address."

**Response submitted by:** ESIS

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| July 30, 2018 | Professional medical services | $1,119.00 | $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. 28 Texas Administrative Code §102.4 sets out general guidelines for non-commission communications.
4. 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 requestor's position statement supported?
2. Is the insurance carrier's reason for denial supported?

**Findings**

1. The requestor states, "This injured worker attended several office visits after this initial evaluation (08-01-2018, 08-07-2018, 08-10-2018). All claims were submitted to ESIS at 1-855-496-5410 (which is the number this claim was faxed to on July 31, 2018) and all have been paid except this date of service."

   Review of the submitted documentation found insufficient evidence to support that all claims were faxed to 1-855-496-5410 except for the July 30, 2018 claim in dispute. The requestor's position is not supported and will not be considered in this review.

2. The requestor is seeking $1,119.00 for professional medical services rendered on July 30, 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,

   > (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.

Review of the information submitted with the request for medical fee dispute did not support timely submission of the services in dispute within 95 days from the date of service. 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**

| | | |
|---|---|---|
| | | February 28, 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**.