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
Todd Price MD

Respondent Name
Service Lloyds Insurance Co

MFDR Tracking Number
M4-19-3365-01

Carrier's Austin Representative
Box 1

MFDR Date Received
March 5, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…We then submitted another reconsideration with a corrected claim changing CPT code 99255 to 99223 however it was brought to our attention we were unable to submit second reconsideration and an Medical Fee Dispute Resolution request had to be submitted to the Texas Department of Insurance."

Amount in Dispute: $355.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We are upholding the original review. DWC Rule 133.20(b) was not adhered too and Carrier received DOS 07/21/2018 on 11/15/2018 and should have received on or before 10/24/2018."

Response submitted by: AViDEL

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 21, 2018	Inpatient hospital care	$355.00	$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. 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. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. The requestor is seeking $355.00 for Code 99223 rendered on July 21, 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.
   >
   > (g) Health care providers may correct and resubmit as a new bill…

Based on the requestor's position statement of, "We then submitted another reconsideration with a corrected claim…" this "corrected claim" was considered a new bill that should have been filed per the above rule requirement of within 95 days of when the services were provided. Insufficient evidence was found to support the timely filing requirement of this "new bill" was met. The insurance carrier's denial is upheld.

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

		March 20, 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.