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
Mission Hospital

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-19-3721-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
April 5, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The facility billed Texas Mutual on 8/22/2018. The claim was sent to the insurance via certified mail (Tracking # 7018 0360 0000 7816). When the package was tracked, the USPS website shows the claim packet was delivered on 09/10/2018, which was well within our timely guidelines."

Amount in Dispute: $4,067.17

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider submitted a request for reconsideration with documentation from the United Stated Postal Service as proof of timely filing. USPS tracking confirmation indicates a delivery to Harlingen, TX which is not TMIC."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 3 – 4, 2018	Outpatient hospital services	$4,067.17	$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

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

Findings

The requestor is seeking $4,067.17 for outpatient hospital services rendered August 3 – 4, 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 submitted documentation found the medical bill (box 80) contained the insurance carrier's address as P.O. Box 12029 Austin, TX 78711. However, the tracking number presented as proof of filing (70180360000070227816) shows the delivery was made to Harlingen, TX 78550 on September 10, 2018.

As no other evidence was submitted to support the timely filing of the services in dispute, 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

Signature	Medical Fee Dispute Resolution Officer	Date
	Peggy Miller	May 2, 2019

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.