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
Arise Healthcare System

Respondent Name
Tx Public School WC Project

MFDR Tracking Number
M4-19-4301-01

Carrier's Austin Representative
Box 1

MFDR Date Received
May 31, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Arise billed the claim within the 95 days from dos 08/24/2019 [sic]. However several (2) appeals were filed disputing the initial denial for no authorization. It was addressed after the 2nd appeal the cpt codes billed did not match the Dr's coding that was authorized. In previous experience a corrected claim has been accepted as an appeal if it's within the 180 days of the previous appeal."

Amount in Dispute: $5,215.55

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The surgical bills received from Arise that were timely submitted in this claim do not match the actual services that IMO preauthorized and Dr. Cassidy performed on August 24, 2018… Although Arise contends that in its "previous experience, a corrected claim has been accepted as an appeal if it's within 180 days of the previous appeal," this assertion does not comport with Commissioner's Rule 133.20. Consequently, Arise has not established that it is entitled to reimbursement for services rendered in this claim."

Response submitted by: Creative Risk Funding

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 24, 2018	Outpatient Hospital Services	$5,215.55	$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. 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 supported?

Findings

1. The requestor is seeking $5,215.55 for outpatient hospital services rendered on August 24, 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.

   The requestor states, "previous experience, a corrected claim has been accepted as an appeal if it's within 180 days of the previous appeal." 28 TAC §133.20 (g) states in pertinent part,

   > Health care providers may correct and resubmit **as a new bill** an incomplete bill that has been returned by the insurance carrier

   Based on the above the corrected claims acknowledged by both parties are subject to the 95 day filing requirement. 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

		June 27, 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.