



# 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**

UT Health Carthage

**Respondent Name**

Facility Insurance Corp

**MFDR Tracking Number**

M4-19-4638-01

**Carrier's Austin Representative**

Box 19

**MFDR Date Received**

June 24, 2019

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "This bill was initially sent to Medicare. The remittance is attached as proof.

**Amount in Dispute:** \$109.25

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The provider has failed to submit any evidence to support that it submitted a medical bill to either a group accident and health insurance carrier or an HMO or to another workers' compensation carrier within 95 days of the September 13, 2018 date of service."

**Response submitted by:** Flahive, Ogden and Latson

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 13, 2018	73501	\$109.25	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.20 sets out requirements of medical bill submission.
- Texas Labor Code 408.0272 sets out the workers compensation timely billing and exceptions guidelines.
- 28 Texas Administrative Code §102.4 sets out general guidelines for non-commission communications.
- 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 of payment supported?

## Findings

1. The requestor is seeking \$109.25 for outpatient hospital services rendered September 13, 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. 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. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied.

Texas Labor Code 408.0272. (b) and (c) states in pertinent part,

(b) Notwithstanding Section 408.0272, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.0272(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:

(1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:

(A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;

(B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or

(C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title;

The respondent states, "The provider has failed to submit any evidence to support that it submitted a medical bill to either a group accident **and** health insurance carrier or an HMO or to another workers' compensation carrier within 95 days of the September 13, 2018 date of service."

The requestor states, "The bill was initially sent to Medicare." The Centers for Medicare and Medicaid Services (CMS) defines Medicare as, "Federal Health Insurance Program." This type of insurance is not listed in 408.0272(b) (1) as an exception to the 95 day filing deadline.

The insurance carriers' denial is supported. No 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

\_\_\_\_\_  
August 6, 2019  
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.**