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 Jacksonville

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-19-4881-01

Carrier's Austin Representative
Box 45

MFDR Date Received
July 15, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I have attached proof from the Jopari Portal to show that we submitted this bill on 9/14/2018."

Amount in Dispute: $198.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office reviewed the documentation submitted by the requestor in their dispute packet and while the requestor does provide a screen shot from their Jopari portal, the status on 9/16/2018 states "Claim was accepted and forwarded to another clearinghouse". The evidence does not support that Jopari forwarded the bill to the Office's E-Bill clearinghouse WCEDI."

Response submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 6, 2018	73564	$198.68	$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. Are the insurance carrier's reason for denial of payment supported?

Findings

1. The requestor is seeking $198.68 for services rendered on September 6, 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.

   28 TAC §102.4 (h) states,

   > Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:
   >
   > > (1) the date received, if sent by fax, personal delivery or electronic transmission or,

   Review of the submitted documentation (837 File) found evidence of transmission to a clearinghouse. Insufficient evidence was found to support the Payer or State Office of Risk Management received the transmission. The insurance carrier's denial is supported.

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

		August 9, 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.