



# 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**

TOPS Specialty Hospital

**Respondent Name**

Insurance Co of the State of PA

**MFDR Tracking Number**

M4-19-4923-01

**Carrier's Austin Representative**

Box 19

**MFDR Date Received**

July 19, 2019

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Proof of timely filing was submitted to carrier for processing; therefore payment is due for billed amount of \$16,140.29."

**Amount in Dispute:** \$8,979.76

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The facts are that the carrier received the provider's bill on January 7, 2019. Since the date of service was September 19, 2108, the provider was required to submit the medical bill to the carrier no later than December 23, 2018. However, since December 23<sup>rd</sup> as a Sunday, and since December 24<sup>th</sup>, December 25<sup>th</sup>, and December 26<sup>th</sup>, are holidays, the provider has through December 27, 2018 to submit the medical bill to the carrier. The provider did not submit the medical bill for another 11 days."

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

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 18, 2018	Outpatient hospital services	\$8,979.76	\$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.
- 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 \$8,979.76 for outpatient services rendered September 19, 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 information found insufficient evidence to support the requestor submitted a claim to the correct workers compensation carrier within the required filing timeline.

The insurance 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

August 21, 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.**