



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

East Texas Medical Center

Respondent Name

Safety National Casualty Corp

MFDR Tracking Number

M4-19-4952-01

Carrier's Austin Representative

Box 19

MFDR Date Received

July 22, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are requesting an overturn of the timely filing denial. We were not informed of worker's compensation insurance until 1/4/19 and immediately sent the bill."

Amount in Dispute: \$617.15

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: August 4, 2018, 99284, \$617.15, \$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. The insurance carrier denied payment for the disputed services with the following claim adjustment codes:
• 29 – Time limit for filing claim/bill has expired

Issues

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

Findings

The Austin carrier representative for Safety National Casualty Corp is Flahive, Ogden & Latson who acknowledged receipt of the copy of this medical fee dispute on July 30, 2019. 28 TAC §133.307 states, in relevant part:

- (d) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
 - (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile **within 14 calendar days after the date the respondent received the copy of the requestor's dispute** [emphasis added]. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

Review of the documentation finds that no response has been received on behalf of the insurance carrier from the carrier representative to date. The division concludes that the insurance carrier failed to respond within the timeframe required by §133.307(d)(1). The division will base its decision on the information available.

1. The requestor is seeking \$617.15 for outpatient hospital services rendered on August 4, 2018. The insurance carrier denied disputed services based on the claim not being filed within 95 days from the date of service.

The requestor included copies of letters sent to the employer and injured worker indicating these as proof of "timely attempts."

28 TAC §133.20 (b) states in pertinent part, health care providers shall submit medical bills no later than the 95th day after the services provided. Exceptions to this rule is found in Labor Code §408.0272(b),(1).

Texas Labor Code 408.0272. (b) (1) allows submission of a claim after 95 days when submitted proof indicates that within the prescribed period one of the exceptions following has occurred;

- (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 "letters" submitted by the requestor do not meet the exception as described above. The insurance carrier's denial based on timely filing is supported. No payment is due.

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

September 26, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.