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
Peyman Pakzaban, MD

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-19-5212-01

Carrier's Austin Representative
Box 54

MFDR Date Received
August 15, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim was initially billed to BCBS, and submitted via electronic billing twice to Texas Mutual. Records of submitted claims attached."

Amount in Dispute: $3,514.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The rationale given by the requestor for the late bill is not consistent with the Rule above. No payment is due."

Response submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 12 - 13, 2019	99222, 22551, 22845, 20931	$3,514.56	$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 – The time limit for filing has expired

Issues

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

Findings

The requestor is seeking $3,514.56 for professional medical services rendered on February 12 and 13, 2019. The insurance carrier denied as the services were not billed within 95 days.

The requestor indicates in their position statement the claim was originally submitted to a commercial insurance carrier and then billed electronically to the correct workers' compensation carrier.

28 TAC §133.20 (b) states when the medical bill was submitted erroneously the health care provider shall include a copy of the original medical bill, an EOB if available and sufficient documentation to support why an exception for untimely submission of a medical bill under §408.0272 should be applied.

Texas Labor Code 408.0272 (b) details the exceptions to timely claim submission when the claim was submitted erroneously to a group accident and health insurance, health maintenance organization or a workers' compensation carrier other than the insurance carrier liable for payment of benefits.

Review of the submitted documentation found "Production – Batch Details" showing submission to the health care providers clearing house or "WEBMD ANSI."

The documentation did not include a copy of the original medical bill or EOB. DWC finds the information is insufficient to support the claim was successfully transmitted or when the health care provider was notified of the correct workers' compensation carrier.

Conclusion

For the reasons stated above, DWC 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

		October 3, 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 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.