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
Metroplex Adventist Hospital

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-20-0189-01

Carrier's Austin Representative
Box 54

MFDR Date Received
September 20, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please note that bill was submitted to BCBS of Texas prior to billing workers comp, and work comp insurance information was not obtained timely which documentations are enclosed as proof of timely filing for review."

Amount in Dispute: $616.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas mutual on 3/21/19 received the bill from Metroplex Health Systems… The BCBS EOB submitted in the DWC60 packet is dated 11/9/2018. The facility had 95 days from date of the EOB to submit the bill to Texas Mutual."

Response submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 22, 2018	97597	$616.53	$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

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

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

Findings

1. The requestor is seeking $616.53 for outpatient hospital services. The insurance carrier denied disputed services based on the claim not being filed within 95 days from the date of service.

   28 TAC §133.20 (b) health care providers shall submit medical bills no later than the 95th day after the services provided unless one of these exceptions found in Labor Code §408.0272(b), (c) or (d) exits.

   Texas Labor Code 408.0272. (b) states in pertinent part, 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 the provider submits proof satisfactory to the commissioner that the provider, within 95 days the claim is erroneously filed for reimbursement with an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;

   Review of the submitted documentation found the explanation of benefits from the health insurance (BC/BS) for date of service October 22, 2018 is dated November 9, 2019. The claim had to be submitted to Texas Mutual within 95 days of this date.

   The claim was received by the correct workers' compensation carrier (Texas Mutual) on March 21, 2019. This date is not within 95 days of when the health care provider was notified of the erroneous claim submission.

   The insurance carrier's denial is upheld. No payment is due.

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, DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		October 17, 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.