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
Baptist St Anthonys

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-20-0016-01

Carrier's Austin Representative
Box 19

MFDR Date Received
September 4, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: $17,371.17

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier maintains that no reimbursement is owed for this service date."

Response submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 9 – 13, 2019	Inpatient hospital services	$17,371.17	$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 reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – The time limit for filing has expired

Issues

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

Findings

1. The requestor is seeking $17,371.17 for inpatient hospital services rendered from February 5 – 13, 2019. 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 a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.

   Texas Labor Code 408.0272 (b) details exceptions to this rule which include, the provider erroneously submitted a claim to a group accident and health insurance, a health maintenance organization or a workers' compensation carrier other the insurance carrier liable for claim.

   Review of the submitted documentation found insufficient evidence to support one of the exceptions found above. The insurance carrier's denial is supported.

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 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.