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
Medical Center of Southeast Texas

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-20-0083-01

Carrier's Austin Representative
Box 54

MFDR Date Received
September 12, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: $407.71

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider has not submitted any documentation or evidence to prove timely filing. No payment is due."

Response submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 16, 2018	Outpatient hospital services	$407.71	$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
   - 731 – Per 133.20(B) provider shall not submit a medical bill later than the 95th day after the date the service

Issues

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

Findings

The requestor is seeking $407.71 for outpatient hospital services rendered on December 16, 2018. 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) 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) and include satisfactory evidence to support a claim was erroneously submitted to a group accident/health insurance which covers the injured employee, a health maintenance organization, or a workers' compensation insurance carrier other than the carrier liable for payment.

The documentation reviewed included the medical bill which indicates the bill was created on September 5, 2019. This date is past the 95th day. Insufficient evidence was found to support an exception to the timely filing requirement of rule 28 TAC §133.20. No additional payment can be 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

		October 9, 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.