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
St Joseph Medical Center

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-20-0100-01

Carrier's Austin Representative
Box 54

MFDR Date Received
September 16, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: None submitted

Amount in Dispute: $12,394.47

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 3/7/2019 to 3/7/2019. Texas Mutual on 7/9/19 received the bill from St Joseph Medical Center."

Response submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 7, 2019	Inpatient hospital services	$12,394.47	$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

Issues

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

Findings

1. The requestor is seeking $12,394.47 for date of service March 7, 2019. 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 unless an exception in Labor Code §408.0272 is found.

   Texas Labor Code 408.0272. (b) (1) allows for submission past 95 days from the date of service when the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with a group accident and health insurance that covers the injured employee, a HMO that the injured employee is enrolled in or a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits.

   Review of the submitted documentation found insufficient evidence was found to support an exception to the timely filing requirement of rule 28 TAC §133.20. 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.