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

MFDR Tracking Number
M4-20-0209-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
September 23, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to EOB received, bill for date of service 11/19/18 was denied due to timely filing. Please note that bill was submitted to BCBS of Texas prior to billing workers comp, and work comp insurance information was not obtained timely."

Amount in Dispute: $616.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual claim … and Metroplex Health System are participants in the WorkWell Network."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 19, 2018	Outpatient hospital services	$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 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
   - D25 – Approved non network provider for WorkWell

Issues

1. Did the respondent raise a new issue?
2. What rule is applicable to claim submission?

Findings

1. The respondent indicates in their position statement that the injured worker and the health care provider are participants in a certified health network which did not allow for MFDR.

   28 133.307 (d)(F) requires consideration of only denial reasons or defenses raised prior to the request for MFDR. Review of the submitted explanation of benefits found no network denial was presented to the requestor prior to the request for MFDR. The respondent's position will not be considered in this review.

2. The requestor is seeking $616.53 for outpatient hospital services rendered November 19, 2018. The insurance carrier denied disputed services based on non-timely submission of claims.

   28 TAC §133.20 (b) states in pertinent part, a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided unless an exception found in the Texas Labor Code 408.0272 (b) that support erroneous submission of a claim to a group accident and health insurance plan that covers the injured employee, a health maintenance program that covers the injured employee or a workers compensation insurance carrier other than the insurance carrier liable for the payment of benefits.

   Review of the submitted documentation found that BCBS of Texas was billed and processed a claim on February 2, 2019.

   The creation date for the medical bill to Texas Mutual was September 17, 2019.

   28 TAC 133.20 (b) requires health care providers to submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill.

   Insufficient evidence was found to support that within 95 days of the BCBS billing, a claim was submitted to Texas Mutual. The insurance carrier's denial is supported.

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

		November 7, 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.