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
M4-20-0301-01

Carrier's Austin Representative
Box 54

MFDR Date Received
October 1, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to EOB received, bill for date of service 10/8/2018 was denied due to timely filing. Please note that bill was submitted to BCBS prior to billing workers comp and work comp information was not obtained timely."

Amount in Dispute: $616.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The rationale given by the requestor for the late bill is not consistent with the exception criteria…"

Response submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 8, 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 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
   - D25 – Approved non-network provider for WorkWell, Tx.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. The requestor is seeking $616.53 for outpatient hospital services rendered October 8, 2018. 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 unless sufficient evidence is submitted that supports an sufficient documentation to support an exception for untimely submission of a medical bill under Labor Code §408.0272 should be applied.

   Labor Code §408.0272 exceptions are erroneous submission to a group accident and health insurance that covers the injured employee, a HMO that covers the injured employee or a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits.

   Insufficient evidence was found to support one of the exceptions found above. The date of service in dispute is October 8, 2018. The claim was submitted to Texas Mutual in April 2019. The insurance carrier's denial is supported.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has not established payment is due. As a result, the amount ordered is $0.00

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is not entitled to additional reimbursement.

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,

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.