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
Metroplex Adventist Hospital

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-20-0336-01

MFDR Date Received
October 7, 2019

Carrier's Austin Representative
Box Number 54

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please note that bill was submitted to BCBS of Texas prior to billing workers comp. and work comp insurance information was not obtained timely which documentations are enclosed as proof of timely filing for review.

Amount in Dispute: $266.70

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The rational given by the requestor for the late bill is not consistent with the exception criteria at 408.0272 of the Labor Code."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
November 26, 2018	99213	$266.70	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305, sets out the procedures for resolving medical disputes.
2. 28 Texas Insurance Code Chapter 1305 applicable to Health Care Certified Networks.
3. 28 Texas Administrative Code §133.20 sets out requirements for claim submission
4. The insurance carrier denied the service in dispute as:
   - 29 – The time limit for filing has expired
   - D25 – Approved non network provider for Workwell, TX Network claimant per Rule 1305.153 (C).

Issues

1. Is the requestor eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.305?
2. What rule is applicable to the submission of claims?

Findings

1. The requestor billed CPT Code 99213 on November 26, 2018 to an injured employee enrolled in Texas Mutual's WorkWell, TX medical network.

   The authority of the Division of Workers' Compensation to apply Texas Labor Code statutes and rules, including 28 TAC §133.307, is limited to the conditions outlined in the applicable portions of the Texas Insurance Code (TIC), Chapter 1305. DWC medical fee dispute resolution section, may address disputes involving health care provided to an injured employee enrolled in an HCN, only if the out-of-network health care provider was authorized by the certified network to do so.

   Review of the submitted information found authorization was issued to the requestor to treat the injured worker on November 1, 2018 on an out-of-network basis. The disputed service will be considered per applicable fee guidelines.

2. 28 TAC §133.20 (c) states, the health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.

   Review of the submitted documentation found **Texas Mutual approved** the out of network care, on November 1, 2018.

   The date of service in dispute is November 26, 2018. The requestor's statement that "work comp insurance information was not obtained timely" is not supported.

   The claim was received by Texas Mutual on March 27, 2019. Insufficient evidence was found to support an exception to the timely submission of a claim.

   The insurance carrier's denial is supported. No additional 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 31, 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 28 Texas Administrative Code §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 (**DWC-045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).