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
St Joseph Medical Center

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-20-0339-01

Carrier's Austin Representative
Box 54

MFDR Date Received
October 7, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The purpose of this letter is to inform you that payment for services provided to the above referenced patient does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code."

Amount in Dispute: $2,586.61

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual found no rationale from the requestor for the late bill."

Response submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 3, 2019	Outpatient hospital services	$2,586.61	$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

Issues

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

Findings

1. The requestor is seeking $2,586.61 for outpatient hospital services rendered on April 3, 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.

   The requestor submitted a screen shot of some sort that indicated something was submitted in the amount of $14,162.67 to Texas Mutual on July 1, 2019.

   28 TAC Rule 102.5 (f)(g) and (h) states,

   > Unless the great weight of evidence indicates otherwise, written communications received by the Commission by means other than electronic filing described in subsection (e) of this section and §124.2 of this title, and §134.802 of this title (relating to Insurance Carrier Medical Electronic Data Interchange to the Commission) shall be deemed to have been sent on:
   >
   > > (1) the date received if sent by fax, personal delivery or electronic transmission or,
   > >
   > > (2) the date postmarked if sent by United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.
   >
   > Written communications include all records, reports, notices, filings, submissions, and other information contained either on paper or in an electronic format.
   >
   > Electronic transmission is defined as transmission of information by facsimile, electronic mail, electronic data interchange or any other similar method and does not include telephonic communication.

Review of the submitted documentation found none of the required elements described above were met by the submitted document.

The insurance carrier's denial is supported. 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

Signature	Medical Fee Dispute Resolution Officer	October 25, 2019 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.