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
UT Health Tyler

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-20-1070-01

Carrier's Austin Representative
Box 45

MFDR Date Received
December 23, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please see attached document for proof of timely filing."

Amount in Dispute: $753.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…the Office has determined we will maintain our denial for 29-Time limit for filing for dates of service 6/5/2019."

Response submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 5, 2019	Outpatient hospital services	$753.30	$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

Issues

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

Findings

The requestor is seeking $753.30 for outpatient emergency room services rendered June 5, 2019. 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 in pertinent part the health care provider shall 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.

Review of the submitted documentation found Blue Cross Blue Shield of Texas notified the health care provider of the claim being subject to workers compensation coverage on July 3, 2019.

Insufficient evidence was found to support within 95 days of July 3, 2019 a claim was submitted to the correct workers' compensation carrier (SORM).

The insurance carrier's denial is supported. No addition payment is recommended.

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

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

Signature	Medical Fee Dispute Resolution Officer	January 24, 2020 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.