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
South Texas Surgical Hospital

Respondent Name
Tx Public School WC Project

MFDR Tracking Number
M4-20-1182-01

Carrier's Austin Representative
Box 1

MFDR Date Received
January 13, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per EOB received bill for date of service 8/9/19 denied due to injury related based on extent of injury, no authorization, and for timely filing. Please note that coding was updated and submitted to carrier 10/15/19 which coding was updated to reflect the compensable injury for Right Shoulder. Also, authorization was obtained and approved for treatment which documentations are enclosed for review."

Amount in Dispute: $11,399.18

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CRF received a new bill for surgical services on November 22, 2019. The bill was not accompanied by any explanation as to why STSH changed the billing codes and filed it more than 95 days after the date of service on August 9, 2019. Consequently, CRF denied the medical bill because it was not timely filed. STSH then resubmitted its bill to CRF on December 2, 2019 for reconsideration. That bill was also denied for untimely filing among other reasons. Although CRF did not receive the January 6, 2020 request for additional reconsideration, that bill was no longer applicable for submission under Rule 133.20(f) because CRF took final action on the December 2nd medical bill."

Response submitted by: Creative Risk Funding, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 9, 2019	Outpatient hospital services	$11,399.18	$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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information or has submission/billing error(s)
   - 167 – This (these) diagnosis(es) is (are) not covered
   - 198 – Payment denied/reduced for exceeded precertification/authorization
   - 219 – Based on extent of injury
   - 216 – Based on the findings of a review organization
   - 29 – The time limit for filing has expired

Issues

1. Does the requestor support timely submission of the medical bill?

Findings

1. The requestor is seeking reimbursement for outpatient hospital services rendered on August 9, 2019 in the amount of $11,399.18. The health care provider submitted several claims for this service. These claims were timely but denied for lack of preauthorization, extent of injury and non-covered diagnosis.

   The health care provider corrected the diagnosis codes and created a new bill on November 22, 2019. This date is past the 95-day timely filing deadline. Even though 28 TAC 134.20 (g) allows the health care provider to correct a claim, the time limit does not begin again.

   The insurance carrier's denial is supported. The information submitted by the requestor did not overcome the denial of timely filing. No 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

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. DWC hereby ORDERS the respondent to remit to the requestor $0.00, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 12, 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.