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
Doctor's Hospital at Renaissance

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-20-1307-01

Carrier's Austin Representative
Box 54

MFDR Date Received
January 24, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Doctors Hospital at Renaissance is kindly requesting that the above claim be processed and paid in accordance with Labor Code 408.0272 (2)(c)(1), and not denied as past timely filing. Please review for reconsideration on PFD our first submission was on 9/18/2020."

Amount in Dispute: $207.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…The initial bill was denied for inaccurate coding. On 10/29/2019 Doctors Hospital at Renaissance submitted a new bill with the correct code. At the time audit, bill was received untimely as the new bill was received beyond 95 days after DOS."

Response submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 17, 2019	G0463	$207.02	$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:
   - 714 – Accurate CPT/HCPCS date of service units, days supply, modifiers are essential for reimbursement. Submit corrections w/I 95 days from DOS

- 29 – The time limit for filing has expired
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

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

Findings

The requestor is seeking $207.02 for outpatient clinic visit. The insurance carrier notified the health care provider on an explanation of benefits dated October 14, 2019 that the billing of Code 99213 was in-accurate and the correct code was G0463.

The corrected claim was received on October 29, 2019. This date was past 95 days from the date of service July 17, 2019. Review of the submitted documentation found insufficient evidence to support an exception found in Texas Labor Code 408.0272 (b) which requires the provider submit satisfactory proof that they erroneously filed for reimbursement with a group accident and health insurance policy, a health maintenance organization or other workers' compensation insurance carrier.

Review of the submitted documentation found insufficient evidence to support one of the exceptions found above. 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

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

		February 20, 2020
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.