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
M4-20-1474-01

Carrier's Austin Representative
Box 54

MFDR Date Received
February 11, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Claim was originally billed to Cigna (their EOB attached) with timely. We received notice from TX Mutual on September 24, 2019 providing claim information."

Amount in Dispute: $1,674.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The rational given by the requestor for the late bill is not consistent with the Rule above."

Response submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 1, 2019	Outpatient hospital services	$1,674.80	$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
   - HCP must submit documentation to support exception to timely filing of bill (408.0272), notification of erroneous submission not included.

Issues

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

Findings

The requestor is seeking $1,674.80 for outpatient hospital services rendered on June 1, 2019. The insurance carrier denied the claim stating, "The time limit for filing has expired."

28 TAC §133.20 (b) states in pertinent parts unless the provider submits satisfactory documentation that the claim was originally submitted to either a group health insurance, health maintenance organization or other workers compensation carrier a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided or 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 evidence that the medical bill was originally submitted to another insurance carrier but insufficient evidence to support that within 95 days of the notification of the erroneous claim, a claim was submitted to the correct workers compensation carrier.

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.

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/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

		March 19, 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.