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
Doctors Hospital at Renaissance

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-20-1652-01

Carrier's Austin Representative
Box 54

MFDR Date Received
March 4, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On August 8, 2019 a letter was submitted to DHR Health at PO Box 2669, Edinburg, TX 78540-26689 requesting for the bill to get submitted to Texas Mutual service is under work related. On December 26, 2019 letter was forward to Doctors Hospital at Renaissance and verification was obtained and request for bill to Texas Mutual submitted on January 3, 2020…"

Amount in Dispute: $810.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: None submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 18, 2019	Outpatient Hospital Visit	$810.92	$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
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - 928 – HCP must submit documentation to support exception to timely filing of bill (408.0272)

Issues

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

Findings

The requestor is seeking reimbursement of outpatient hospital services rendered in March 2019. The insurance carrier denied their claim as past timely filing. The health care provider indicated that they were unaware of the work- related injury at the time of service.

Review of the submitted "history and physical" note taken at the time of service indicates in part, "Patient was working construction…"

28 TAC §133.20 (b) states in pertinent part unless an exception found in the Texas Labor Code §408.0272 of satisfactory proof that an erroneous claim was submitted to a group accident and health plan, health maintenance organization or a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits, a health care provider shall not submit a medical bill later than the ninety-fifth day after the date the services are provided.

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

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.

Authorized Signature

		May 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.