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
Southwest General Medical Center

Respondent Name
Safety First Insurance Co

MFDR Tracking Number
M4-20-1766-01

Carrier's Austin Representative
Box 19

MFDR Date Received
March 16, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…our claim was sent to you within timely."

Amount in Dispute: $981.81

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The date of service was October 3, 2019. The 95th day following that date was January 6, 2020. Yet, the provider did not create the UB-04 until January 21, 2020, which was 15 days following the deadline date. Moreover, the documents manifest that the bill was submitted electronically to the carrier on January 22, 2020 which was 16 days following the deadline date. Accordingly, the provider is not entitled to reimbursement."

Response submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 3, 2019	Outpatient hospital services	$981.81	$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 claim/bill has expired

Issues

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

Findings

1. The requestor is seeking $981.81. The insurance carrier denied disputed services based on non-timely submission of the claim.

   28 TAC §133.20 (b) states in pertinent part unless proof is submitted to support erroneous submission of a claim to a group/health insurance policy, a health maintenance organization, or other workers compensation insurance carrier other than the carrier liable for the payment of benefits, a health care provider shall not submit a medical bill later than the 95th 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

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

		April 8, 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.