



# 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**

UT Health Tyler

**Respondent Name**

Texas Mutual Insurance

**MFDR Tracking Number**

M4-20-1813-01

**Carrier's Austin Representative**

Box 54

**MFDR Date Received**

March 23, 2020

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "This bill was denied for timely filing. We have attached proof that we learned of workers compensation on 2/10/2020."

**Amount in Dispute:** \$397.42

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "There is not evidence submitted that UT Health Tyler tried to obtain work comp information within 95 days of date of service."

**Response submitted by:** Texas Mutual Insurance Co

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 23, 2019	Outpatient Emergency Room	\$397.42	\$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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.20 sets out requirements of medical bill submission.
- Texas Labor Code 408.0272 sets out the workers compensation timely billing and exceptions guidelines.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 29 – The time limit for filing has expired
  - 731 – Per 133.20(B) provider shall not submit a medical bill later than the 95<sup>th</sup> day after the date of service

**Issues**

Is the insurance carrier’s reasons for denial of payment supported?

**Findings**

The requestor is seeking \$397.42. The insurance carrier denied disputed services based on lack of timely filing. 28 TAC §133.20 (b) states a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided unless satisfactory proof is found that an erroneous claim was submitted to a policy of group accident and health insurance, a health maintenance organization, a workers’ compensation insurance carrier other than the insurance carrier liable for the payment of benefits or a catastrophic event.

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/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	April 22, 2020 Date
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***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.**