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
Employers Insurance Co of Wausau

MFDR Tracking Number
M4-20-1893-01

Carrier's Austin Representative
Box 1

MFDR Date Received
April 10, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This bill was first billed on 8/14/2019 therefore, this is not to be considered as past filing."

Amount in Dispute: $306.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The documentation submitted by the provider has been reviewed and fails to meet the guideline for timely submission."

Response submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 13, 2019 listed on DWC 60 August 7, 2019 on submitted documentation	G0463, 92134	$306.90	$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:
   - 4271 – Per TX Labor Code Sec. 413,016, providers must submit bills to payors within 95 days of the date of service

Issues

1. Is the insurance carrier's reason for denial of payment supported?

Findings

1. The requestor is seeking $306.90. The insurance carrier denied disputed services for past timely filing.

   28 TAC §133.20 (b) states except if satisfactory proof exists that an erroneous claim was submitted to a group or accident policy, health maintenance organization, to a workers' compensation carrier other than the one liable for payment, or a catastrophic event 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

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

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.