



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

Doctor's Hospital at Renaissance

Respondent Name

Employers Insurance Co of Wausau

MFDR Tracking Number

M4-20-1908-01

Carrier's Austin Representative

Box 01

MFDR Date Received

April 10, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We rendered services on good faith based on the information that was exchanged and therefore are also requesting that our claim be reprocessed for payment."

Amount in Dispute: \$886.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The UB submitted has a bill date which exceed 95 days from DOS as the Medicare EOB shows Date of 03/26/2019 and UB shows bill date of 01/23/2020."

Response submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 19, 2019	66821	\$886.62	\$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:
 - 4271 – Per Texas Labor Code Sec. 413.016, providers must submit bills to payors within 95 days of the date of service

Issues

Is the insurance carrier’s reason for denial or reduction of payment supported?

Findings

The requestor is seeking \$886.62. The insurance carrier denied disputed services for past timely filing. 28 TAC §133.20 (b) states except when satisfactory proof exists that an erroneous claim was submitted to a group or accident policy, health maintenance organization, 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

		April 22, 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.