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 Quitman

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-20-2021-01

Carrier's Austin Representative
Box 54

MFDR Date Received
April 17, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Worker's compensation claim information was not available on the emergency visit. The account was initially set up as private pay. Our notes are attached to show that we learned of worker's comp by incoming phone call on February 18th, 2020 which should restart our timely filing deadline."

Amount in Dispute: $2,461.42

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual has noted in the claim file that the adjuster reached out to the facility and left claim and billing information on 6/21/2019… The rationale given by the requestor for the late bill is not consistent with the Rule above."

Response submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 20, 2019	Outpatient hospital services	$2,461.42	$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

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

Issues

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

Findings

1. The requestor is seeking $2,461.42 for outpatient hospital services rendered in June 2019. The insurance carrier denied disputed services as claim not received timely.

   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 one of the exceptions found in Labor Code §408.0272(b), (c) or (d) or satisfactory proof of an erroneous claim submission to a group health insurance, health maintenance organization or workers' compensation carrier other than the insurance carrier liable for payment of benefit.

   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

Signature	Medical Fee Dispute Resolution Officer	May 8, 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.