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
Luba Casualty Insurance Co

MFDR Tracking Number
M4-20-2228-01

Carrier's Austin Representative
Box 53

MFDR Date Received
May 4, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The bill was denied for timely filing. We have attached the BlueCross BlueShield Remit to show proof of timely. This bill was initially sent to the commercial insurance carrier. We learned of a worker's compensation claim on 3/4/2020."

Amount in Dispute: $10,231.63

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Since provider has not provided any evidence of any submission sent to or received from blue Cross Blue Shield, the exception to Rule 133.20(b) does not apply; therefore, provider's claim must be denied."

Response submitted by: Hoffman Kelley Lopez LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 18, 2019	Outpatient Hospital Services	$10,231.63	$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:
   - B66 – Denied. Based on TX Guidelines, bills submitted after the 95th day after the DOS are disallowed

Issues

Are the insurance carrier's reasons for denial of payment supported?

Findings

The requestor is seeking $10,231.63 for outpatient hospital services rendered November 18, 2019. The insurance carrier denied disputed services based on untimely submission of the medical bill.

The requestor has stated, "This bill was initially sent to the commercial insurance carrier. We learned of a worker's compensation claim on 3/4/2020."

28 TAC §133.20 (b) states in pertinent part, an exception to the 95 day filing deadline found in Texas Labor Code 408.0272 (b) can be made if the provider submits satisfactory proof that within 95 days of the notification of the erroneous billing to a group health insurance, health maintenance organization or a workers' compensation insurance carrier other than the insurance carrier liable for the payment, a bill was submitted to the correct carrier. The bill submitted to the correct carrier should include a copy of the original bill, EOB and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied.

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

		June 16, 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.