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
Deep East Texas Self Insurance Fund

MFDR Tracking Number
M4-20-2393-01

Carrier's Austin Representative
Box 44

MFDR Date Received
June 4, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This bill and appeal denied for timely filing. The BlueCross BlueShield remit were attached as proof of timely as well as our notes to show that we learned of work comp on 11/13/2019."

Amount in Dispute: $1,550.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the submitted documentation from the provider using a printout referring to Account Notes Inquiry does not provide proof of timely filing or meet the requirement of the rule. Per 28 TAC 102.4(h), acceptable proof of timely filing was not submitted."

Response submitted by: Injury Management Organization, Inc

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 26 – 27, 2019	Outpatient Hospital Services	$1,550.76	$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
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

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

Findings

The requestor is seeking $1,550.76 for outpatient hospital services rendered in August 2019. The insurance carrier denied disputed services as not filed timely.

28 TAC §133.20 (b) states in pertinent part, a health care provider shall submit a medical bill no later than the 95th day after the date the services are provided.

Exceptions to this requirement found in Labor Code are when the provider submits proof satisfactory to the commissioner that the provider submitted an erroneous claim with a group accident and health insurance, health maintenance organization or workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits and within 95 days of the notification of the erroneous submission, a claim was submitted to the correct workers' compensation carrier.

Review of the submitted documentation found insufficient evidence to support that within 95 days of the health care provider being notified of the erroneous claim, a claim was submitted to the correct workers' compensation carrier. 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 15, 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.