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
MHHS the Woodlands Hospital

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-20-2609-01

Carrier's Austin Representative
Box 54

MFDR Date Received
June 30, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On October 11, 2019, MH received a phone call from adjuster [redacted] who provided them with the billing information."

Amount in Dispute: $4,630.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Additional review of the claim file shows that Memorial Hermann Hospital Health System had claim information as of 8/21/2019 as they sent Texas Mutual a Release of Information document."

Response submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 1, 2019	Outpatient Hospital Services	$4,630.50	$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 reason for denial of payment supported?

Findings

1. The requestor is seeking reimbursement of outpatient hospital services rendered in August 2019. The insurance carrier denied disputed services with claim adjustment reason code 29 – "The time limit for filing has expired."

   The requestor states "The patient did not provide us with the carrier information… and …a phone call from the adjuster [redacted] who provided them the billing information."

   Exceptions to the filing deadline are found in 28 TAC §133.20 (b) which references Texas Labor Code 408.0272 (b) (1) that states,

> Notwithstanding Section 408.0272, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.0272(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:
>
> (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:
>
> (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;
>
> (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or
>
> (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title;
>
> (2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

Review of the submitted documentation found the injured worker was billed and a partial payment made. These circumstances do meet 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	July 17, 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.