



# 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**

Baptist St Anthony's Health System

**Respondent Name**

State Office of Risk Management

**MFDR Tracking Number**

M4-20-2630-01

**Carrier's Austin Representative**

Box 45

**MFDR Date Received**

July 2, 2020

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** None submitted.

**Amount in Dispute:** \$231.73

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The Office did not find document that substantiates the two exceptions outlined in Texas Labor Code §408.0272 in the dispute packet, therefore the Office will maintain our denial for CARC code 29-Time limit for filing has expired.

**Response submitted by:** State Office of Risk Management

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 18, 2019	Outpatient Hospital Services	\$231.23	\$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:
  - 29 – The time limit for filing has expired

**Issues**

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

**Findings**

The requestor is seeking \$231.73 for outpatient hospital services rendered in October 2019. The insurance carrier denied disputed services based on untimely submission of the medical claim.

28 TAC §133.20 (b) states in pertinent part exceptions to the submission of the medical claim within 95 days after the service is provided is found in Labor Code §408.0272(b), (c) or (d).

Texas Labor Code 408.0272 allows an exception when the provider submits satisfactory proof of an erroneous submission of the medical claim to a group accident and health plan, health maintenance organization or workers’ compensation insurance carrier other than the insurance carrier liable for the payment of benefits.

The requestor offered no explanation or documentation to support why an exception exists. 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	Date
		July 24, 2020

**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.**