TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Wadley Regional Medical Center

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-20-2659-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
July 13, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Original submission for this claim was 10/16/2019. We received correspondence dated 10/28/2019 with our original claim submission, please reference this as proof of timely filing."

Amount in Dispute: $8,782.65

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The rationale given by the requestor for the late bill is not consistent with the Rule above. Reference Rule 133,10 133.2(4) for Complete medical bill."

Response Submitted by:

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 2, 2019	Inpatient Hospital Services	$8,782.65	$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 §133.10 sets out required billing forms/formats.
3. 28 Texas Administrative Code §133.20 sets out requirements of medical bill submission.
4. he insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - 29 – The time limit for filing has expired
    - 193 – The original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is the requestor's position supported?
2. Is the insurance carrier's denial of payment supported?

Findings

1. The requestor is seeking reimbursement of $8,782.65 for outpatient hospital services rendered in October 2019. The requestor offers as proof of meeting the timely claim submission a notice from Texas Mutual dated November 1, 2019 that indicates the submitted UB 04 was missing information (Identity of the Employer) that did not allow further action on the attached document.

   28 TAC §133.10 (f) (2) (DD) states in pertinent part the following data content or data elements are required for a complete institutional medical bill related to Texas workers' compensation health care, employer's name (UB-04/field 58) is required. Based on this missing element, the submitted UB 04 was incomplete.

   The requestor's position is not supported as the referenced document does not support the timely submission of a bill that could be considered complete to the correct workers' compensation carrier.

2. 28 TAC §134.20 28 TAC §133.20 (b) states in pertinent part unless an exception found in Texas Labor Code 408.0272 (b) the provider shall not submit a medical bill later than the ninety-fifth day after the date the services are provided.

   These exceptions include satisfactory proof that an erroneous claim was submitted to a group accident and health insurance policy, a health maintenance organization or a workers' compensation carrier other that the insurance carrier liable for the payment of benefits.

   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

		July 31, 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, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

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.