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
Texas Mutual Insurance Co

MFDR Tracking Number
M4-20-2810-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
July 29, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This bill has been denied for timely filing although the SGIC Remit was attached as well as our notes to show that we learned of a worker's compensation claim on 2/10/2020. The bill was sent on 2/13/2020."

Amount in Dispute: $1,007.37

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: UT Health Tyler submitted a DWC60 packet disputing denial of untimely filing. Documentation submitted with the initial bill did not include proof of timely filing or an explanation to support their position of the late bill received on 2/13/2020. …The injured party paid above the amount in dispute ($1,007.37). Texas Mutual considers the bill paid in full by the patient."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 25, 2019	Outpatient Hospital Services	$1,007.37	$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 claim submission.
3. 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 denial of payment supported?

Findings

The requestor is seeking reimbursement of $1,007.37 for outpatient hospital services rendered April 25, 2019. The insurance carrier denied the claim for past timely filing.

28 TAC §133.20 (b) states in pertinent part, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill.

Texas Labor Code 408.0272 (c) states in pertinent part a health care provider who erroneously submits a claim to a group accident health insurance, health maintenance organization or workers' compensation carrier other than the one liable for payment forfeits the provider's right to reimbursement if the provider fails to submit the claim to the correct workers' compensation insurance carrier within ninety-five days after the date the provider is notified of the erroneous claim submission.

Review of the submitted documentation found an explanation of benefits dated May 14, 2019 that was a zero pay and a "Routing Slip" that showed private pay and $1110 due. This is not sufficient evidence to support when or how the requestor was notified of the erroneous claim submission and that within ninety-five days of notification of the erroneous payor a claim was submitted to Texas Mutual. Based on the above, the insurance carrier's denial is supported.

Additionally, the respondent submitted evidence of a demand bill to the injured worker dated February 14, 2020 with a notation of a payment of $1110.00 by the injured worker. No payment is due.

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

		August 28, 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.