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 Co

MFDR Tracking Number
M4-20-2812-01

Carrier's Austin Representative
Box 54

MFDR Date Received
July 29, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Originally this bill was submitted to patient's primary insurance (EOB is attached). Wadley Regional was notified in 01/2020 about this being work related. Claim was filed to Texas Mutual on 2/05 within 95 days of being notified."

Amount in Dispute: $10,422.70

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "DWC60 packet was received with the Medicare EOB, check date 9/26/2019. The provider did not previously submit the EOB within 95 days of notification, therefore untimely rule still applied. The EOB would have needed to be received on or before 12/29/2019 to be considered timely filing. …The rational given by the requestor for the bill is not consistent with the Rule above."

Response submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 25 – September 7, 2019	Inpatient Hospital Services	$10,442.70	$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 reasons for denial or reduction of payment supported?

Findings

1. The requestor is seeking $10,422.70 for an inpatient hospital stay from August 25 to September 7, 2019. The insurance carrier denied disputed services as the time limit for filing has expired.

   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 95 days after the date the provider is notified of the erroneous claim submission.

   Insufficient evidence was found to support 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.

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 , 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.