



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Metdalspl LLC

Respondent Name

Frisco ISD

MFDR Tracking Number

M4-23-1991-01

Carrier's Austin Representative

Box Number 17

DWC Date Received

April 12, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 14, 2022	Rev 110	\$1,333.30	\$0.00
July 14, 2022	Rev 250	\$1,350.89	\$0.00
July 14, 2022	Rev 252	\$630.27	\$0.00
July 14, 2022	Rev 258	\$53.23	\$0.00
July 14, 2022	Rev 271	\$1,450.91	\$0.00
July 14, 2022	Rev 272	\$2,477.75	\$0.00
July 14, 2022	Rev 278	\$5,206.27	\$0.00
July 14, 2022	Rev 300	\$214.71	\$0.00
July 14, 2022	Rev 301	\$906.31	\$0.00
July 14, 2022	Rev 305	\$491.62	\$0.00
July 14, 2022	Rev 309	\$188.84	\$0.00
July 14, 2022	Rev 320	\$836.61	\$0.00
July 14, 2022	Rev 360	\$1,4361.07	\$0.00
July 14, 2022	Rev 361	\$494.28	\$0.00
July 14, 2022	Rev 370	\$2,498.79	\$0.00
July 14, 2022	Rev 420	\$89.48	\$0.00
July 14, 2022	Rev 424	\$177.82	\$0.00
July 14, 2022	Rev 710	\$767.03	\$0.00
July 14, 2022	Rev 730	\$247.27	\$0.00
July 14, 2022	Rev 740	\$2,511.08	\$0.00
July 14, 2022	Rev 922	\$771.33	\$0.00

Total	\$37,059.86	\$0.00
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Requestor's Position

"The requestor did not submit a position statement but rather a document titled "Reconsideration" addressed to Texas Dept of Insurance that states, "...our records indicate that the claim was filed timely as the bill was submitted to the carrier on 9/08/2022 and timely filing did not expire until 10/17/2022."

Amount in Dispute: \$37,059.86

Respondent's Position

"The expenses in question were incurred on 7/14/2022. Our first receipt of the bill was on 10/28/2022 and on 11/10/2022 it was denied for timely filing. On 2/20/2023 we received a reconsideration and the original determination was maintained on 3/1/2022. Although the reconsideration request documents proof of timely filing was attached, we are unable to locate the proof indicated."

Response Submitted by: Claims Administrative Services, Inc.

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.20 sets out requirements of medical bill submission.
3. Texas Labor Code 408.0272 sets out the workers compensation timely billing and exceptions guidelines.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 29 – The time limit for filing has expired
- 350 – Bill has been identified as a request for reconsideration or appeal
- 719 – Per Rule 133.20, a medical bill shall not be submitted later than the 95th day

after the date of service

Issues

1. Did the requestor support timely submission of medical claim?

Findings

1. The requestor is seeking reimbursement of inpatient hospital services rendered in July 2022. The requestor states, "our records indicate that the claim was filed timely as the bill was submitted to the carrier on 9/08/2022". The requestor submitted a copy of a "Query" from their Intranet, This information is insufficient to support the claim was submitted to the correct worker's compensation carrier.

DWC Rule 28 TAC §133.20 (b) states in pertinent part,

(b) Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.

Texas Labor Code 408.0272. (b) states in pertinent part,

(b) 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 insufficient evidence to support timely submission of the claim to the correct workers' compensation carrier or that an exception to timely filing exists.

No payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

_____	_____	_____
Signature	Medical Fee Dispute Resolution Officer	Date

May 5, 2023

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico CompConnection@tdi.texas.gov.