Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4812 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Southwest Homecare

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-14-0279-01

Carrier's Austin Representative Box
Box Number 54

MFDR Date Received
September 26, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…we are disputing the denial we received from the insurance for timely filing as that claim should be processed and paid. Please find the claim non-acceptance letter, Denial EOB with the copy of the corrected claim."

Amount in Dispute: $2,625.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor submitted a bill for home health services that Texas Mutual received 5/21/12. Ninety-five days from dates 1/11/12 through 2/9/12 are outside the 95 days. Further, the requestor has date 2/17/12 listed on Table of Disputed Services, yet Texas Mutual has no record of receiving a bill for that date. And review of the requestor's DWC-60 packet shows no bill for that date. "

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 11, 2012 through February 17, 2012	Home Health Services	$2,625.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
4. No Explanation of Benefits found within submitted documentation.

Issues

1. What is applicable rule pertaining to bill submission?
2. What is the timely filing deadline applicable to the medical bills for the services in dispute?
3. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. 28 Texas Administrative Code §133.20 (g) states, "Health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier." Review of the submitted documentation finds;
    a. Statement of requestor, "…incorrect type of billed on 05/02/2012, However when we sent corrected claim…"
    b. Notice from Texas Mutual dated May 16, 2012, notifying requestor claim was unable to be processed.
    c. The beginning date of service was January 11, 2012. Ninety five days from this date would be April 16, 2012. The ending date of service on the submitted medical bill copy is February 9, 2012. Ninety five days from this date would be May 14, 2016.
    d. Carrier submitted copy of corrected bill for the services in dispute that was received May 21, 2012. Per Rule 133.20(g) this was a new bill. Therefore, this receipt date is past the timely filing requirements of the Division rules.
2. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." The requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided.
3. Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." Review of the submitted information finds no documentation to support that a medical bill was submitted within 95 days from the date the services were provided. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute has forfeited the right to reimbursement due to untimely submission of the medical bill for the services in dispute.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 13, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §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 the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.