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**
MEMORIAL HERMANN HOSPTIAL

**Respondent Name**
ACIG INSURANCE CO

**MFDR Tracking Number**
M4-15-0843-01

**Carrier's Austin Representative**
Box Number 47

**MFDR Date Received**
November 05, 2014

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "According to the Hospital's records, the patient was emergently admitted for treatment for the work related injury he sustained on the above dates of service. Subsequent to the patient's admission, on November 15, 2013 the patient told the Hospital he did not have insurance but would call the Hospital back with more information. On November 26, 2013, December 12, 2013, December 27, 2013, and January 14, 2014, the Hospital sent letters and made phone calls to the patient in an attempt to obtain payment and coverage information. On January 27, 2014 the patient called the Hospital saying he would provide workers' compensation coverage information, and on January 31, 2014 the patient came to the Hospital and provided his workers' compensation coverage information. This was the first time the Hospital was aware of workers' compensation coverage, and who the proper carrier was. The Hospital then billed Carl Warren & Company on February 27, 2014, but the bill was denied for timely filing. We submitted a request for reconsideration to Carl Warren & Company, requesting they reconsider the denial and issue proper reimbursement, but that request was denied."

**Amount in Dispute:** $11,486.52

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on November 13, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| November 08, 2013 to November 09, 2013 | Outpatient Hospital Service | $11,486.52 | $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 resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
3. 28 Texas Administrative Code §102.4 establishes rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
5. Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical claim.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 125 – Denial/Reduction due to submission/billing error
   - 29 – Time limit for filing claim/bill has expired
   - B15 – Procedure/Service is not paid separately
   - GP – Service delivered under OP PT care plan
   - RM2 – Time limit for filing claim has expired
   - RN – No paid under OPPS: services included in APC rate
   - 25 – Separate E&M Service, Same Physician
   - 59 – Distinct Procedural Service
   - CH – O percent impaired, limited or restricted
   - R25 – Procedure billing restricted/see state regulations
   - RM7 – Invalid code for CMS payment-resubmit w/ valid code
   - TC – Technical Component

**Issues**

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

**Findings**

1. The insurance carrier denied the disputed services with claim adjustment reason codes: 125 – "Denial/Reduction due to submission/billing error", 29 – "Time limit for filing claim/bill has expired", B15 – "Procedure/Service is not paid separately", GP – "Service delivered under OP PT care plan", RM2 – "Time limit for filing claim has expired", RN – "No paid under OPPS: services included in APC rate", 25 – "Separate E&M Service, Same Physician", 59 – "Distinct Procedural Service", CH – "O percent impaired, limited or restricted", R25 – "Procedure billing restricted/see state regulations", RM7 – "Invalid code for CMS payment-resubmit w/ valid code" and TC – "Technical Component". 28 Texas Administrative Code §133.20(b) requires 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." Texas Labor Code §408.0272(b) provides that:

   > Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(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; or

(2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the health care provider was required to submit the medical bill not later than 95 days after the date the disputed services were provided.

2. Texas Labor Code §408.027(a) states 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. Consequently, the requestor has forfeited the right to reimbursement due to untimely submission of the medical bill, pursuant to Texas Labor Code §408.027(a).

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional 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.

***ORDER***

**Authorized Signature**

| | | |
|---|---|---|
| | | 5/1/15 |
| 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 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 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 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**.