



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

COMANCHE COUNTY AMBULANCE SERVICE

**Respondent Name**

TEXAS MUTUAL INSURANCE COMPANY

**MFDR Tracking Number**

M4-15-0928-01

**Carrier's Austin Representative Box**

Box Number 54

**MFDR Date Received**

November 17, 2014

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "please consider paying our claim since the employee/employer didn't get us the insurance information within the timely manner."

**Amount in Dispute:** \$966.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Texas Mutual on 9/11/14 received the bill from COUNTY OF COMANCHE AMBULANCE SERVICE. . . . Rule 133.20(b) states, 'Except as provided in Labor Code §408.0272(b), (c), (d), a health care provider shall not submit a medical bill later than the 95<sup>th</sup> day after the date the services are provided. . . . The rationale given by the requestor for the late bill is not consistent with the Rule above."

**Response Submitted by:** Texas Mutual Insurance Company

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 23, 2013	Ambulance Services	\$966.00	\$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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
- Texas Labor Code §408.027 sets out the rules for timely submission of claims by health care providers.
- Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical bill.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 29 – THE TIME LIMIT FOR FILING HAS EXPIRED.
  - 731 – PER 133.20 PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE THE SERVICE, FOR SERVICES ON OR AFTER 9/1/05

**Issues**

1. What is the timely filing deadline applicable to the medical bills for the services in this 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: 29 – “THE TIME LIMIT FOR FILING HAS EXPIRED.”; and 731 – “PER 133.20 PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE THE SERVICE, FOR SERVICES ON OR AFTER 9/1/05.” 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.” Review of the submitted information finds no documentation to support that the health care provider submitted the medical bill prior to the 95th day after the date the services were provided. Consequently, the requestor has forfeited the right to reimbursement for the disputed services due to untimely submission of the medical bill.

**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 on 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	<b>Grayson Richardson</b> Medical Fee Dispute Resolution Officer	<b>April 15, 2015</b> Date
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## **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 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*** along 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**

Health care providers may verify workers' compensation insurance coverage and contact information from our website at [www.tdi.texas.gov/wc/employer/coverage.html](http://www.tdi.texas.gov/wc/employer/coverage.html) or for additional assistance please call the TDI-DWC Insurance Coverage section at **800-372-7713**.