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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MCC LIVINGSTON

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-15-0992-01

Carrier's Austin Representative
Box Number: 54

MFDR Date Received
NOVEMBER 24, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Requestor provided services to [Claimant] on the date of 1/25/2014. The charges incurred in the course of the Claimant's treatment totaled $904.00. At that time, hospital staff was not provided with any worker's compensation carrier information. MCC LIVNGSTON called the employer, [redacted] and were informed by Carolyn Weaver that the claim was a worker's compensation claim and that services were not authorized. She also stated that the treating doctor had the worker's compensation information. MMC LIVINGSTON then informed Carolyn Weaver that we were not provided this information and that we were the facility. She then stated that she would fax the information on 3/18/2014. On 3/25/2014 and 3/31/2014 calls were placed to the employer regarding the information required. On 4/01/2014, MMC LIVINGSTON mailed a letter to the employer requesting the worker's compensation information. On 4/17/2014 Carolyn Weaver now stated that she would email the information. The information regarding the carrier was finally received on 5/29/2014 after numerous calls and emails. These charges were billed to and subsequently denied by the TEXAS MUTUAL. It was the Carrier's contention that the 'the time limit for filing has expired.' The Requestor appealed the Carrier's determination in the Request for Reconsideration on date. Applicable mailing records indicate that it was received by TEXAS MUTUAL on the date of 8/26/2014. Following this request for Reconsideration, the TEXAS MUTUAL maintained its original determination. 'the time limit for filing has expired'."

Amount in Dispute: $137.59

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "MMC LIVINGSTON provided services to the claimant on the date above. The rationale given by the requestor for the late bill is not consistent with the Rule above. No payment is due."

Response Submitted by: INJURY MANAGEMENT ORIGANIZATION, INC.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 25, 2014	Hospital Outpatient Services	$137.59	$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. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. 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.
   - W3, 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 724 – No additional payment after a reconsideration of service.

Issues

1. Is there an extent of injury issue?
2. 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. The insurance carrier initially denied the services using denial code "219 – Based on extent of injury." The health care provider submitted a corrected bill changing the diagnosis code. Therefore, no extent of injury exists.
2. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, "except as provided in Texas Labor Code §408.0272(b)(c) and (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, 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. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied..." Review of the documentation submitted by the requestor finds no convincing documentation 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 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

		March 31, 2015
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 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.