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
TX HEALTH OF STEPHENVILLE

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-15-2232-01

Carrier's Austin Representative Box
Box Number 54

MFDR Date Received
March 20, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am filing this MDR to appeal for appropriate payment on this claim and to preserve our rights.

Since TDI moved to a 200% of MAR for outpatient services on 03/1/08 for hospital claims, we have reviewed the Medicare allowance and decided the insurance reimbursement does not meet this criteria. Medicare would have allowed this facility $1,573.38 for the MAR at 200%. Based on their payment of $0.00, a supplemental payment of $1,573.38 is due. This was originally billed to the patient. I have attached a copy of the patient statement sent to the patient on 7/25/14 showing the uninsured discount applied of $1,426.95. The Hospital didn't receive the workman's compensation insurance information until 9/29/14. It was then billed to Texas Mutual on 9/30/14. I have also enclosed the hospital system notes for verification. The employer was very uncooperative and kept hanging up on use when we called to try to get the insurance information."

Amount in Dispute: $1,573.38

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "TX HEALTH STEPHENVILLE provided services to the claimant on the date above. TX HEALTH STEPHENVILLE submitted its bill to the claimant based on information provided by the claimant … The following is the requestor's rationale for the late bill: This was originally billed to the patient. I have attached a coy of the patient statement sent the patient on 7/25/14 showing the uninsured discount applied of $1,426.95. The hospital didn't receive the workers' compensation insurance information until 9/29/14.

The rationale given by the requestor for the late bill is not consistent with the Rule above.
No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 23, 2014	Outpatient Hospital Service	$1,573.38	$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 sets out the rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of claims by health care providers.
5. Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical bill.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-29- THE TIME LIMIT FOR FILING HAS EXPIRED
   - 731 – PER 133.20(B) PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE THE SERVICE
   - CAC-W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL
   - CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY
   - 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL
   - 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDRATION OF SERVICES FOR INFORMATION CALL 1-800-937-6824
   - 928 – HCP MUST SUBMIT DOCUMENTATION TO SUPPORT EXCEPTION TO TIMELY FILING OF BILL (408.0272). NOTIFICATION OF ERRONEIOUS SUBMISSION NOT INCLUDED

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. 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." 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 requestor in this dispute 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, 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 has forfeited the right to reimbursement due to untimely submission of the medical bill for the disputed services."

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

		4/24/15
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 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** or for additional assistance call the TDI-DWC Insurance Coverage section at **800-372-7713**.