TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
EAST TEXAS MEDICAL CENTER

Respondent Name
CITY OF HOUSTON

MFDR Tracking Number
M4-16-0798-01

Carrier's Austin Representative
Box Number 29

MFDR Date Received
NOVEMBER 20, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We originally billed for this date of service on 12/19/2014, which we were told it was kicked out for lacking the social security number for the patient. Per rule 133.200 there is nothing that requires the social security number to make a claim complete, we also feel the carrier could have obtained this information themselves easier than a provider and this claim should have never been kicked out on the first submission. We also resubmitted this claim on 1/02/15 which is still within the 95 day guidelines and should have processed for payment. The first date of submission was electronically on 12/19/14 and then again via mail on 1/02/2015. We submitted this claim well within the 95 day deadline from the date of service and should have been processed for payment release. Our proof of timely filing includes the last UB that was submitted and dated on 1/02/2015."

Amount in Dispute: $113,172.19

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the submitted documentation no additional payment is being made at this time. Upon review, this claim was received by our office twice, once on 03/16/15 and once on 05/18/15. Prior to that it appears that the bill was rejected by the Clearing House. When first received the bill was denied for documentation as the medicals were not included only the itemized statement. So for the second submission it was denied based on Rule 133.20(h) for timely filing."

Response Submitted by: Injury Management Organization, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 21, 2014 through December 9, 2014	Inpatient Hospital Services	$113,172.19	$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. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim

by a health care provider.

2. 28 Texas Administrative Code §133.20, effective January 29, 2009, sets out the procedure for healthcare providers submitting medical bills.
3. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
4. 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.
   - Incomplete billing info or support documentation. Charge will be evaluated upon receipt.
   - 16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. In order to appropriately review the submitted date of service, the report/medical record of office notes are requested.

Issues

Did the requestor support position that the disputed bills were submitted timely? Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the services in dispute based upon reason code "29-The time limit for filing has expired."

   Texas Labor Code §408.027(a) states, "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. 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, "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." A review of the submitted documentation does not contain any evidence such as a fax, personal delivery, electronic transmission, or certified green card to support the disputed bill was sent to the respondent within the 95 days deadline.

The Division finds that the requestor did not sufficiently support it's position that the disputed bill was submitted timely in accordance with Texas Labor Code §408.027(a). As a result, reimbursement is not recommended.

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

		12/17/2015
Signature	Medical Fee Dispute Resolution Officer	Date
		12/17/2015
Signature	Health Care Business Management Director	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.