



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
ETMC FIRST PHYSICIANS

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-16-2321-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
APRIL 7, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The injured employee received numerous statements with no response also numerous phone calls were made. The provider was not advised that this was a workers comp claim until 11/16/15 I called Texas Mutual at that time and we received workers comp insurance."

Amount in Dispute: \$1,223.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requester billed for an inpatient hospital E&M service and an EKG report for the date above. Texas Mutual received the bill on 11/19/15. (Attachment) From 8/2/15 to 11/19/15 is 109 days, which should establish the bill was untimely...None of the untimely exception criteria at 408.0272 apply to the requestor's untimely bill submission."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Rows include August 2, 2015 with CPT codes 99291 and 93010, and a TOTAL row.

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. Texas Labor Code §408.0272, effective September 1, 2007, provides for exceptions for timely submission of a claim by a health care provider.

3. 28 Texas Administrative Code §133.20, effective January 29, 2009, sets out the procedure for healthcare providers submitting medical bills.
4. 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 provider shall not submit a medical bill later than the 95<sup>th</sup> day after the date the service, for services on or after 9/1/05.
  - CAC-W3, 350-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.
  - 724-No additional payment after a reconsideration of services.

### **Issues**

1. Did the requestor support position that the disputed bill was submitted timely?
2. Does the disputed bill meet exception for filing untimely? 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 codes "CAC-29-The time limit for filing has expired," and "731-Per 133.20 provider shall not submit a medical bill later than the 95<sup>th</sup> day after the date the service, for services on or after 9/1/05."

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."

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.

2. Texas Labor Code §408.0272(b)(1) states "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."

The requestor wrote "The injured employee received numerous statements with no response also numerous phone calls were made. The provider was not advised that this was a workers comp claim until 11/16/15."

The Division finds that the requestor's rationale for the delay in submission is not an exception to timely filing outlined in Texas Labor Code §408.0272(b)(1). As a result, reimbursement is not recommended.

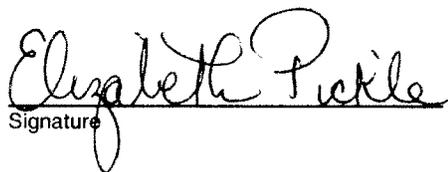
### **Conclusion**

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.

**Authorized Signature**

  
Signature

Elizabeth Pickle, RHIA  
Medical Fee Dispute Resolution Officer

04/21/2016  
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.**