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
TEXAS HEALTH HEB

Respondent Name
AMERICAN ZURICH INSURANCE COMPANY

MFDR Tracking Number
M4-18-0337-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 10, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Claim submitted in timely to Sedgwick on 02/02/2017 by electronic submission, but rejected by Jopari on 02/03/2017. Once the error was fixed the complete claim as resubmitted to Sedgwick."

Amount in Dispute: $4,947.27

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the provider had up to 95 days following the date of service to submit its medical bill to the carrier. The 95th day following the date of service of November 21, 2016 was February 24, 2017. The carrier received the initial medical bill on March 17, 2017. It follows that he provider did not timely submit the medical bill to the carrier. Accordingly, the provider is not entitle to reimbursement."

Response Submitted by: Flahive, Odgen & Latson, Attorneys At Law, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 21, 2016	Outpatient Hospital Services	$4,947.27	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
4. Texas Labor Code §408.0272 provides certain exceptions for untimely submission of a medical bill.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 937 – SERVICES(S) ARE DENIED BASED ON HB7 PROVIDER TIMELY FILING REQUIREMENT. A PROVIDER MUST SUBMIT A MEDICAL BILL TO THE INSURANCE CARRIER ON OR BEFORE THE 95TH DAY AFTER THE DATE OF SERVICE
   - 29 – THE TIME LIMIT FOR FILING HAS EXPIRED.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 1014 – THE ATTACHED BILLING HAS BEEN RE-EVALUATED AT THE REQUEST OF THE PROVIDER. BASED ON THIS RE-EVALUATION, WE FIND OUR ORIGINAL REVIEW TO BE CORRECT. THEREFORE, NO ADDITIONAL ALLOWANCE APPEARS TO BE WARRANTED.

Issues

1. Did the health care provider fail to timely submit the medical bill to the insurance carrier?

Findings

1. The insurance carrier denied the disputed services with claim adjustment reason codes:
   - 937 – SERVICES(S) ARE DENIED BASED ON HB7 PROVIDER TIMELY FILING REQUIREMENT. A PROVIDER MUST SUBMIT A MEDICAL BILL TO THE INSURANCE CARRIER ON OR BEFORE THE 95TH DAY AFTER THE DATE OF SERVICE
   - 29 – THE TIME LIMIT FOR FILING HAS EXPIRED.

   28 Texas Administrative Code §133.20(b) requires that, except as provided in 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 §408.027(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."

   Texas Labor Code §408.0272(b) provides certain exceptions to the 95-day time limit for bill submission:

   > 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 the 95th day following the date the disputed services were provided.

   The service date was November 21, 2016. The 95th day following the service date was Friday, February 24, 2017. While the provider has presented documentation to support electronic claim submission to Optum Property and Casualty Clearinghouse before the 95th day. The provider's documentation also supports that the bill was rejected by the clearinghouse due to incomplete information. That bill was thus not forwarded on to the insurance carrier.

   The requestor states, "Once the error was fixed the complete claim was resubmitted to Sedgwick." However, no information was provided to indicate what date the error was fixed or when the complete claim was resubmitted.

   The respondent, on the other hand, has provided information to support that the completed bill was not received until March 17, 2017 — a date later than the 95th day following the date of service.

   Based on the submitted information, the division concludes the requestor has failed to support that a complete bill was timely submitted to the carrier by the 95th day. Consequently, the requestor has forfeited the right to reimbursement due to untimely submission of the claim, pursuant to Rule §133.20(b) and Labor Code §408.027(a).

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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	May 18, 2018
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 Rule §133.307.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.