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
Providence Memorial

Respondent Name
Fedex Freight Inc

MFDR Tracking Number
M4-19-3624-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 27, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…this is a legitimate claim that was medically authorized and timely submitted."

Amount in Dispute: $10,099.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…the Medical Review Division does not have jurisdiction to make a determination on any medical fee disputes because the claimant is in the Coventry Health Care Network."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 29 – 31, 2018	Inpatient Hospital Services	$10,099.16	$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 requirements of medical bill submission.
3. 28 Texas Administrative Code §102.4 sets out general guidelines for non-commission communications.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – The time limit for filing has expired

Issues

1. Is the insurance carrier's position supported?
2. Are the insurance carrier's reasons for denial of payment supported?

Findings

1. The requestor is seeking $10,099.16 for inpatient hospital services rendered from March 29 – 31, 2018. The respondent states, "The claimant is in the Coventry Health Care Network." Although Coventry Health Care Network is listed as a certified network on the Division's webpage, the carrier did not provide convincing evidence that the injured employee is enrolled in this network.

   The Division concludes that the carrier's position is not supported and the service in dispute will be reviewed per applicable Division fee guidelines.

2. The insurance carrier denied disputed services "the time limit for filing has expired." 28 TAC §133.20 (b) states in pertinent part,

   > (b) Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.

   28 TAC §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.

   Review of the submitted medical bill finds an explanation of benefits with a process date of July 10, 2018, that shows the vendor received the claim on July 6, 2018. The 95th day from the discharge date is July 4, 2018. As this was a legal holiday, the next day would be July 5, 2018. But, as the supported receipt date is July 6, 2018, the claim was received beyond the 95th day from discharge. The insurance carrier's denial is supported.

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

______________________	______________________	April 24, 2019
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 MFDR 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.