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
HUNT REGIONAL MEDICAL CENTER

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-19-3668-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
April 1, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Hunt Regional Medical Center was not notified prior to 12/19/2018 that Texas Mutual was the primary insurance to bill. In addition, Employer East Texas Towers denied having worker's compensation insurance... Claim was submitted in good faith on 12/19/2018 to Texas Mutual and claim was filed within 95 days of notification."

Amount in Dispute: $31,152.21

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The hospital's explanation for untimeliness does not meet the exception criteria at 408.0272 of the Labor Code."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
July 5, 2018 to July 9, 2018	Outpatient Hospital Services	$31,152.21	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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:
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 29 – THE TIME LIMIT FOR FILING HAS EXPIRED.
   - 714 – ACCURATE CODING IS ESSENTIAL FOR REIMBURSEMENT, CPT/HCPCS BILLED INCORRECLTY. CORRECTIONS MUST BE SUBMITTED W/I 95 DAYS FROM DOS
   - 731 – PER 133.20(B) PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE THE SERVICE.

- W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- DC4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION. FOR INFORMATION CALL (800) 859-5995 X3994.
- 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

Did the requestor forfeit the right to reimbursement due to untimely submission of the medical bill?

Findings

The insurance carrier denied disputed services with adjustment codes:

- 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.

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 §408.0272(b) provides certain exceptions to the 95-day time limit for medical bill submission. A health care provider does not forfeit the right to reimbursement 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 any of the exceptions described in Texas Labor Code §408.0272(b). The provider was thus required to submit the bill no later than the 95th day after the dates of service.

Texas Labor Code §408.027(a) states, "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."

Review of the submitted information finds no documentation to support the medical bill was submitted within 95 days from the dates of service. Consequently, the division finds the requestor has forfeited the right to reimbursement due to untimely submission of the medical bill, in accordance with Texas Labor Code §408.027(a).

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

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	April 25, 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 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 division must receive the request within twenty days of your receipt of this decision. The request may be faxed, mailed or personally delivered either to the division, using the contact information listed on the form, or to the field office handling the claim.

The party seeking review must deliver a copy of the request to all parties involved in the dispute at the same time the request is filed. Include a copy of this *Medical Fee Dispute Resolution Findings and Decision* together with any other information required by 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.