TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

DOCTORS HOSPITAL AT RENAISSANCE

Respondent Name

MCALLEN INDEPENDENT SCHOOL DISTRICT

MFDR Tracking Number

M4-19-3980-01

Carrier's Austin Representative

Box Number 29

MFDR Date Received

April 29, 2019

Response Submitted By

No response from insurance carrier

REQUESTOR'S POSITION SUMMARY

"Doctors Hospital at Renaissance is kindly requesting that the above claim be processed and paid in accordance with Labor Code 408.0272 (2)(c)(1) and not denied as past timely filing…. Attached is a print screen showing where we first submitted to Tristar's correct address on 07/16/2018."

RESPONDENT'S POSITION SUMMARY

The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
June 29, 2018	Hospital Outpatient Visit	$204.02	$0.00

AUTHORITY

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. 28 Texas Administrative Code §102.4 establishes rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
5. Texas Labor Code §408.0272 provides certain exceptions for untimely submission of a medical bill.
6. The division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, receipt acknowledged May 8, 2019. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute.
   If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier has not responded. Accordingly, this decision is based on the information available at the time of review.

7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - P15 - No additional reimbursement allowed after review of appeal/reconsideration.
    - P12 - Your billing has been paid in accordance with the Inpatient Hospital Fee Schedule or the Outpatient Fee Schedule.
    - T029 – The time limit for filing has expired.
    - T193 - No additional reimbursement allowed after review of appeal/reconsideration.
    - Ti13 – level 1 appeal means a request for reconsideration under 133.250

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 claim adjustment reason code:

- T029 – 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, "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)(1) provides certain exceptions to the 95-day time limit for medical bill submission. The provider does not forfeit the right to reimbursement if the provider submits satisfactory proof that within the period prescribed by §408.027(a), the provider erroneously filed the bill with:

> (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;

The health care provider requests payment in accordance with Labor Code §408.0272, asserts, "Attached is a print screen showing where we first submitted to Tristar's correct address on 07/16/2018" In order to show they meet the exception set out in Texas Labor Code §408.0272(b)(1), above.

The date of service in dispute is June 29, 2018. The 95th day following the service date is Tuesday, October 2, 2018. The first EOB from Tristar indicates a bill receipt date of January 7,.2019. This date is later than the 95th day after the date the services were provided. No documentation was found to support an earlier date of bill submission.

Furthermore, no documentation was presented to support what date the provider was notified of the correct workers' compensation insurance carrier. And no EOBs or other documentation were presented to support that the bill was ever submitted to the correct carrier (McAllen Independent School District) nor to support that reconsideration was requested from the correct carrier. The division concludes the submitted information is insufficient to support timely submission or to support any of the exceptions in Labor Code §408.0272. Consequently, the division finds in accordance with Labor Code §408.027(a) that the requestor has forfeited the right to reimbursement due to untimely submission of the medical bill.

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 above, the division finds the requestor has not established that additional payment is due. As a result, the amount ordered is $0.00.

ORDER

In accordance with Texas Labor Code §413.031, based on the information submitted for review, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

______________________________	Grayson Richardson	July 19, 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.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). 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 field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute 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.