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
UT HEALTH JACKSONVILLE HOSPITAL

Respondent Name
OLD REPUBLIC INSURANCE COMPANY

MFDR Tracking Number
M4-19-4010-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
April 29, 2019

Response Submitted By
No response submitted

REQUESTOR'S POSITION SUMMARY

The requestor did not submit a position statement for consideration in this review.

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
October 18, 2018	Emergency Department Services	$496.39	$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. 28 Texas Administrative Code §133.307(d)(1) states, "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 division notified the insurance carrier with a copy of the MFDR request; however, the carrier has not responded to date. 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:
   - 29 – THE TIME LIMIT FOR FILING HAS EXPIRED.
   - P12 – REIMBURSEMENT HAS BEEN CALCULATED ACCORDING TO STATE FEE SCHEDULE GUIDELINES.
   - Z652 - Recommendation of payment has been based on a procedure code which best describes the services rendered.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - W3 – Request for reconsideration.

Issues

1. Did the insurance carrier respond to the medical fee dispute?
2. Did the requestor submit a position statement?
3. Did the requestor forfeit the right to reimbursement due to untimely submission of the medical bill?

Findings

1. The Austin carrier representative for Old Republic Insurance Company is White Espey, PLLC. The division provided a copy of the MFDR request to White Espey, 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. Consequently, this decision is based on the information available at the time of review.

2. Rule §133.307(c)(2)(N) requires an MFDR request to include a position statement of the disputed issue(s) that shall include:

   (i) the requestor's reasoning for why the disputed fees should be paid or refunded,
   (ii) how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues, and
   (iii) how the submitted documentation supports the requestor's position for each disputed fee issue;

   No position statement was found with the submitted MFDR request; the requestor thus failed to meet the requirements of Rule §133.307(c)(2)(N). This decision is based upon all information available at the time of review.

3. The insurance carrier denied disputed services with claim adjustment reason code 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 §408.0272(b)(1) provides certain exceptions to the 95-day time limit for medical bill submission. 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 date 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."

   The date of service is October 18, 2018. The "creation date" field on the bill indicates the bill was printed on February 4, 2019. This is consistent with the insurance carrier's first dated explanation of benefits (EOB), which indicates a bill receipt date of February 4, 2019. This date is beyond the 95th day following the date of service. No information was provided to support an earlier date of submission for the bill.

   The requestor failed to support that the medical bill was submitted within 95 days from the date of service. The division therefore 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 26, 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.