

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

<u>Requestor Name</u> CONTINUECARE HOSPITAL OF ODESSA

<u>Respondent Name</u> TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number M4-20-1714-01 <u>Carrier's Austin Representative</u> Box Number 54

MFDR Date Received March 9, 2020 <u>Response Submitted by:</u> Texas Mutual Insurance Company

REQUESTOR'S POSITION SUMMARY

"I am appealing the claim with the fact we have an authorization for patient to be seen for medical necessity and all additional documents requested are included in the package. Please review claim and submitted documentation(s), and reconsider for payment on the claim."

RESPONDENT'S POSITION SUMMARY

"Continue Care Hospital did not submit required information necessary to process the bill per Rule 134.04 and a Letter of Agreement signed by both partied [sic] the provider and Texas Mutual... The Provider also did not include and [sic] itemized statement or clinical records of the treatment provided. Preauthorization approved until date of service 11/30/2018, the denial for preauthorization was added to the bill incorrectly. All other denials for missing Medicare Number, Medical records and itemized statement remain correct."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 20, 2018 through November 27, 2018	Long-Term Acute Care (LTAC)	\$252,224.71	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.

- 2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes: Explanation of Benefit
 - 879 Late Appeal
 - CAC-138 Appeal procedures not followed, or time limits not met
 - 879 Rule 133.250 (B) Healthcare provider shall submit the request for reconsideration no later than 10 months from the date of service
 - 225 Please provide clinical records of the treatment
 - CAC-16 Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
 - 225 The submitted documentation does not support the services being billed. We will re-evaluate this upon receipt of the clarifying information
 - 225 The letter of agreement requires use of Medicare LTCH pricer. Please provide LTCH Medicare number as stated directed
 - CAC-197 Precertification/authorization/notification absent
 - 240 Preauthorization not obtained
 - 895 Requires itemized statement for hospital services

<u>Issues</u>

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

 The requestor seeks reimbursement for long-term acute care services rendered on September 20, 2018 through November 27, 2018. 28 TAC §133.307(c) (1) states in pertinent part, "Timeliness. A requestor shall timely file the request with the DWC's MFDR Section or waive the right to MFDR. The DWC shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute."

The dates of the services in dispute are September 20, 2018 through November 27, 2018. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on March 9, 2020. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in 28 TAC §133.307(c) (1) (B).

The DWC concludes that the requestor has failed to timely file this dispute with the DWC's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the DWC 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 TLC §413.031, the DWC has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

		June 26, 2020
Signature	Medical Fee Dispute Resolution Officer	Date
		June 26, 2020
Signature	Health and Safety Deputy Commissioner	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 TAC §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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed, or personally delivered to the DWC 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 DWC. **Please include a copy of the** *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.