



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

Intergris Baptist Medical

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-20-2529-01

Carrier's Austin Representative

Box 54

MFDR Date Received

June 17, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This document is to serve as an account overview for the purposes of showing the extensive work up to try to obtain the required information to file a claim for reimbursement of services provided by Intergris Baptist Medical 6/18/2019 thru 06/27/2019."

Amount in Dispute: \$210,053.94

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Intergris Baptist Medical Center received documentation via case management report on 6/26/2019 provided to them by Coventry which listed claim information for the claimant and Texas Mutual Billing Information and address. The rationale given by the requestor for the late bill is not consistent with the Rule above. The facility received claim information within a week of the patient admission."

Response submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 18 – 27, 2019	Inpatient Hospital Services	\$210,053.94	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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. Texas Labor Code 408.0272 sets out the workers compensation timely billing and exceptions guidelines.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 29 – Time limit for filing has expired

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Did the health care provider waive the right to medical fee dispute?

Findings

1. The requestor is seeking the billed charges of \$210,064.95 for inpatient hospital services rendered June 18 – 27, 2019. The insurance carrier denied disputed services with claim adjustment reason code 29 – “The time limit for filing has expired.”

The rule applicable to the timely submission of medical claims is found in 28 Texas Administrative Code(TAC) §133.20 (b) which states in pertinent part, a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided except as provided in Labor Code §408.0272(b), (c) or (d).

Texas Labor Code 408.0272 (b) states in pertinent part,

(b) Notwithstanding Section 408.0272, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.0272(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim 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;

(2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

Review of the submitted documentation from the requestor details their efforts to contact the injured worker and their employer. The submitted documentation also supports that the requestor billed the employer on July 7, 2019. As billing the employer is not one of the exceptions listed in Texas Labor Code 408.0272(b), the requestor had 95 days to submit the bill to the insurance carrier. A medical bill was submitted to the correct carrier Texas Mutual via facsimile on January 30, 2020 after the 95 day filing deadline.

The respondent's position statement indicates that the requestor was notified of the correct workers' compensation carrier on June 26, 2019. The respondent submitted a document titled “Case Summary” which asked the requestor to send the bill with appropriate documentation to TMI Billing and provided a billing address.

Based on our review, none of the exceptions afforded in Texas Labor Code 408.0272 (b) were found and the requestor was notified of the correct insurance carrier and billing address prior to the 95 day deadline. The requirement of 28 TAC 133.20 regarding timely submission of medical bills was not met. The insurance carrier's denial is upheld.

2. Per the submitted documentation the requestor billed the employer for the services in dispute on July 7, 2019. TAC §133.20(j)(1)(C) states in part “A health care provider who elects to submit medical bills to an employer waives, for the duration of the election period, the rights to...medical dispute resolution as provided by Labor Code §413.031.” The requestor has waived the right to medical fee dispute resolution.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC 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 requestor has not established payment 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

		August 5, 2020
Signature	Medical Fee Dispute Resolution Officer	Date

Signature	Deputy Commissioner of Health and Safety	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 instructions on the form. The request must be received by DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to 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. **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.