TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Coon Memorial Hospital & Home

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-22-0546-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
November 16, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 8 – 21, 2001	Inpatient	$65,297.68	$0.00
July 9 – 21, 2021	Pro Fee	$2,368.00	$0.00
	Total	$67,846.68	$0.00

Requestor's Position

Nobody at Texas Mutual can explain to me why the CAH rates should be on a bill format.

Amount in Dispute: $67,846.68

Respondent's Position

The type of bill on appeal was not corrected, the denial was maintained as the type of bill submitted was 111 not 181 billing guidelines. ...Professional fee for Jonathan Pesco were received on DWC60, however Texas Mutual does not have the bill on record as being received, therefor is not eligible for MDR dispute per Rule 133.307.

Response submitted by: Texas Mutual

Findings and Decision

Authority

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

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.20 sets out the guidelines for medical bill submission.
3. 28 TAC §133.20 sets our requirements of claim submission.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- 892 – Incorrect TOB (Box 4) for CAH. Please submit Medicare Part A per diem rate.
- DC4 – Type of bill not appropriate for CAH. Please resubmit on appeal with correct type of bill (Box 4-UB04).
- 193 Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Did the requestor support submission of the medical claim for professional services?
2. Is the insurance carrier's denial based on incorrect type of bill supported?

Findings

1. The requestor submitted a 1500 claim form for professional medical services as part of their DWC060 for dates of service July 9, through July 21, 2021.

   Insufficient evidence was found to support this medical bill was sent either electronically, via fax or mailed within 95 days from the date of service as required by DWC Rule 133.20 (a). No payment can be recommended for the professional services.

2. The requestor is seeking reimbursement of inpatient hospital services rendered from July 8 – 21, 2021 in a critical access hospital. The insurance carrier denied the bill stating the type of bill was incorrect.

   The medical bill in dispute contained bill type 0111. The submitted medical claim

indicates NPI number 1639176456 which is shown to be Critical Access Hospital and Skilled Nursing Facility. The correct bill type for skilled nursing inpatient services provided in a Critical Access Hospitals is 0181.

The insurance carrier asked the health care provider to resubmit the disputes services with type of bill 0181. No evidence was submitted showing a corrected bill was submitted to the insurance carrier.

The insurance carrier's denial is supported as DWC Rule 133.20 (c) states in pertinent part a health care provider shall include correct billing codes when submitting medical bills. No payment can be recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

		January 10, 2022
Signature	Medical Fee Dispute Resolution Officer	Date
		January 10, 2022
	Director of Medical Fee Dispute Resolution	Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field

office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.