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
MHHS Southeast Hospital

Respondent Name
Star Indemnity & Liability Co

MFDR Tracking Number
M4-22-1046-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
January 27, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 16, 2021		$17.25	$0.00
May 17, 2021		$68.00	$0.00
May 18, 2021		$30.50	$0.00
May 16, 2021	96374	$564.00	$0.00
May 16, 2021	96375	$502.75	$0.00
May 16, 2021	96376	$245.00	$0.00
May 17, 2021	96376	$1470.00	$0.00
May 18, 2021	96376	$490.00	$0.00
May 16, 2021	85652	$96.00	$0.00
May 16, 2021	80048	$348.00	$0.00
May 26, 2021	83605	$188.50	$0.00
May 16, 2021	87839	$139.50	$0.00
May 18, 2021	80202	$49.00	$0.00
May 17, 2021	86140	$104.50	$0.00
May 16, 2021	85025	$223.00	$0.00
May 17, 2021	85025	$223.00	$0.00
May 18. 2021	85025	$223.00	$0.00
May 16, 2021	U0002	$128.25	$0.00
May 17, 2021	76882	$1055.25	$0.00
May 16, 2021	10060	$1139.00	$0.00
May 16, 2021	99284 25	$3288.50	$0.00

May 16, 2021	J0692	$56.00	$0.00
May 16, 2021	J3370	$216.00	$0.00
May 17, 2021	J0692	$112.00	$0.00
May 17, 2021	J3370	$216.00	$0.00
May 18, 2021	J0692	$28.00	$0.00
May 16, 2121	G0378	$7496.00	$0.00
	Total	$18717.00	$0.00

Requestor's Position

Both the employer and patient did not provide us with the workers' compensation insurance information.

Amount in Dispute: $18,717.00

Respondent's Position

The carrier's position remains the same as identified in those EOBs. Among the defenses is the failure of the provider to submit the medical bill to the carrier within ninety-five days of the date of service.

Response Submitted by: Flahive Ogden & Latson

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 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.20 sets out requirements of medical bill submission.

3. Texas Labor Code 408.0272 sets out the workers compensation timely billing and exceptions guidelines.

Denial Reasons

The insurance carrier [reduced or denied] the payment for the disputed services with the following claim adjustment codes:

- 29 – The time limit for filing claim/bill has expired
- 193 – Original payment/decision is being maintained. Upon review it was determined

that this claim was processed properly
- 18 – Exact duplicate claim/service

Issues

1. Did the requestor support timely submission of medical claim?

Findings

1. The requestor is seeking reimbursement of outpatient hospital charges rendered in May 2021. The insurance carrier denied based on non-timely submission of claim.

   DWC Rule 28 TAC §133.20 (b) states in pertinent part,

   (b) Except as provided in Labor Code §408.0272(b), (c) or (d), 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) 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 found insufficient evidence to support any of the exceptions listed above apply in this dispute. No payment is 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

		February 28, 2021
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 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.