



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Citizens Medical Center

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-22-1322-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

March 3, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 23, 2021	0551 G0300	\$383.00	\$0.00
June 30, 2021	0551 G0300	\$383.00	\$0.00
Total		\$766.00	\$0.00

Requestor's Position

The requestor did not submit a position statement with the request for MFDR documentation.

Amount in Dispute: \$766.00

Respondent's Position

"Documentation submitted (reference DWC60 pg. 9-10) does not support the claim was submitted or accepted by the "payer" as Texas Mutual Insurance. No additional 835 or ANSI 837 report was submitted to confirm if the file was accepted or rejected by payer – Texas Mutual."

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 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.
4. 28 TAC §102.5 sets out the general rules for written and electronic communications.

Denial Reasons

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

- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly
- 29 – The time limit for filing has expired
- 721 – Per 133.20(b) provider shall not submit a medical bill later than the 95th day after the date of service

Issues

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

Findings

1. The requestor is seeking reimbursement of skilled nursing services rendered in June 2021.. The insurance carrier states the medical bills were not submitted within ninety-five days.

DWC Rule 28 TAC §133.20 (b) states in pertinent part, 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, 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 of any exception to rule requiring claim be submitted with ninety-five days.

2. DWC Rule §102.5 (f) states in pertinent part, unless the great weight of evidence indicates otherwise, written communications received by the division will be deemed to have been sent on:

(1) the date received if sent by fax, personal delivery, or electronic transmission; or

(2) the date postmarked if sent by United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent will be the next previous day that is not a Sunday or legal holiday.

Review of the submitted "Episode Manager: View: Claims" was insufficient to support the electronic transmission of the disputed claims to the correct workman's comp insurance carrier. 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

Signature

Medical Fee Dispute Resolution Officer

June 14, 2022

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 electrónico CompConnection@tdi.texas.gov.