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
North Central Baptist Hospital

Respondent Name
Sagamore Insurance Co

MFDR Tracking Number
M4-22-1458-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
March 16, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 17, 2021	637	37.00	$0.00
March 17, 2021	636	4478.00	$0.00
March 17, 2021	300	1330.00	$0.00
March 17, 2021	250	2506.00	$0.00
March 17, 2021	710	10270.00	$0.00
March 17, 2021	370	23780.00	$0.00
March 17, 2021	740	825.00	$0.00
March 17, 2021	360	126612.00	$0.00
March 17, 2021	278	141279.50	$0.00
March 17, 2021	310	728.00	$0.00
March 18, 2021	637	93.00	$0.00
March 18, 2021	300	3160.00	$0.00
March 18, 2021	636	94.00	$0.00
March 18, 2021	424	562.00	$0.00
March 18, 2021	762	2770.00	$0.00
March 18, 2021	434	562.00	$0.00
March 19, 2021	300	1877.00	$0.00
March 19, 2021	637	265.00	$0.00
March 19, 2021	636	58.00	$0.00

March 19, 2021	762	2880.00	$0.00
March 19, 2021	399	1328.00	$0.00
March 20, 2021	637	234.00	$0.00
March 20, 2021	300	1711.00	$0.00
March 20, 2021	430	844.00	$0.00
March 20, 2021	762	1364.00	$0.00
March 20, 2021	420	548.00	$0.00
March 20, 2021	120	1791.00	$0.00
March 21, 2021	420	217.00	$0.00
March 21, 2021	300	2808.00	$0.00
March 21, 2021	637	259.00	$0.00
March 21, 2021	120	1791.00	$0.00
March 21, 2021	399	1328.00	$0.00
March 22, 2021	430	422	$0.00
March 22, 2021	637	217	$0.00
March 22, 2021	300	3194.00	$0.00
	Total	$342022.50	$0.00

Requestor's Position

The Hospital's records reflect the patient was injured in work related injury. The Hospital provided the medically necessary services on the above date of service. The Hospital billed Protective Insurance Services, but the bill was denied. The Hospital requested Protective Insurance Services review denial and issue payment. However, despite the Hospital's efforts and Request for Reconsideration Protective Insurance Services has not rendered proper payment.

Amount in Dispute: $342022.50

Respondent's Position

CorVel maintains the requestor North Carolina Baptist Medical Center is not entitled to reimbursement for date of service 03-17-21-3/23/21 in the amount of $311,545.50 based on failure to timely submit a complete medical bill in accordance with health care provider billing rules set forth under 28 TAC Chapter General Medical Provisions.

Response Submitted by: CorVel

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 – Time limit for filing claim/bill has expired
- W3 – Appeal/reconsideration

Issues

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

Findings

1. The requestor is seeking reimbursement for inpatient hospital services rendered in March 2021. The insurance carrier denied based on the untimely submission of the medical bill.

   DWC 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 information to support an exception to the timely filing requirement listed above. 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

Authorized Signature

		April 18, 2022
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.