TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Providence Memorial Hospital

Respondent Name
Liberty Insurance Corp

MFDR Tracking Number
M4-22-1507-01

Carrier's Austin Representative
Box Number 1

DWC Date Received
March 16, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 21, 2021	300	3401.00	$0.00
June 21, 2021	730	749.00	$0.00
June 21, 2021	320	1287.00	$0.00
June 25, 2021	637	50.98	$0.00
June 25, 2021	636	2544.00	$0.00
June 25, 2021	250	354.00	$0.00
June 25, 2021	360	14096.00	$0.00
June 25, 2021	710	8049.00	$0.00
June 25, 2021	370	3322.00	$0.00
	Total	33852.98	$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 dates of service. The Hospital billed Liberty Mutual, but the bill was denied. However, despite the Hospital's efforts and Request for Reconsideration, Liberty Mutual has not rendered payment.

Amount in Dispute: $33852.98

Respondent's Position

The bill has been reviewed and no payment is due at this time and the bill was denied correctly as the bill was not received within 95 days form the Date of Service. The Date of Service for this treatment is 06/25/2021 and bill was submitted to Liberty Mutual on 10/8/2021 which is 104 days from Date of Service. Per Rule 133.20(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.

Response Submitted by: Liberty 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 Texas Administrative Code §102.4 sets out the general rules for non-division communications.

3. 28 TAC §134.20 sets out requirements of medical bill submission.

4. 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:

- 4271 – Per TX Labor Code Sec. 408.027, providers must submit bills to payors within 95 days of the date of service.
- X598 – Claim has been re-evaluated based on additional documentation submitted; no additional payment is recommended.

Issues

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

Findings

1. The requestor is seeking for an inpatient hospital stay rendered in June 2021. The insurance carrier denied the claim based on untimely submission of the claim.

   DWC Rule §102.4 (h) (1) states in pertinent part unless the great weight of evidence indicates otherwise, written communications will be deemed to have been sent on the date received by fax, personal delivery, or electronic transmission.

   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 the submission of the claim or that an exception to the timely filing requirement exists. 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

		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.