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
Emergenchealth LLC

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-22-2466-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
July 25, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 18, 2021	01392 QZ	$567.00	$0.00
	Total	$567.00	$0.00

Requestor's Position

"According to Title 28, Part 2 of the Texas Department Division of Workers' Compensation, Chapter 133, Subchapter B, 2, Section 408.027(c) "established that once a health care provider has been notified of the erroneous submission, the health care provider has 95 days to submit the claim for payment to the correct workers' compensation insurance carrier." Please review the attached information and determine this carrier owes our provider for the service provided."

Amount in Dispute: $567.00

Respondent's Position

"Research of the claim file has determined the facility was made aware of Texas Mutual as the carrier per adjuster notification 9/20/2021. The facility submitted medical documentation to Texas Mutual that was received on 9/22/2021, in this documentation the facility included the patient demographic facesheet that includes Texas Mutual as the carrier. The facility had 95 days to submit the bill from notification date 9/20/2021. Texas first received the bill which was denied

untimely on 2/11/2022. … Our position is that no payment is due."

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.

Denial Reasons

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

- CAC-29 The time limit for filing has expired.
- 731 – Per 133.20(B) provider shall not submit a medical bill later than the 95th day after the date the service.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 928 – HCP must submit documentation to support exception to timely filing of bill (408.0272). Notification of erroneous submission not included.

Issues

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

Findings

1. The requestor is seeking reimbursement for professional medical services rendered in September 2021. The insurance carrier denied the claim based on untimely submission of medical claim. The requestor states in their position statement they were not notified of the

workers' compensation claim until January 18, 2022, when the injured worker contacted their office.

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 an exception to the timely filing requirement described 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 entitled to additional reimbursement for the disputed services.

Authorized Signature

		August 23, 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.