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
Ysleta ISD

MFDR Tracking Number
M4-23-0551-01

Carrier's Austin Representative
Box Number 4

DWC Date Received
October 31, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 3, 2021	250	47.02	$0.00
November 3, 2021	C1762	55795.00	$0.00
November 3, 2021	80053	617.00	$0.00
November 3, 2021	28200	23813.00	$0.00
November 3, 2021	370	5222.00	$0.00
November 3, 2021	J0690	348.00	$0.00
November 3, 2021	J1100	40.00	$0.00
November 3, 2021	J2250	240.00	$0.00
November 3, 2021	J2405	12.00	$0.00
November 3, 2021	J2704	40.00	$0.00
November 3, 2021	J2795	300.00	$0.00
November 3, 2021	J3010	784.00	$0.00
November 3, 2021	J7120	529.00	$0.00
November 3, 2021	710	6088.00	$0.00
November 3, 2021	93005	786.00	$0.00
	Total	$11160.98	$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 CLAIMS ADINISTRATOR, but the bill was denied. However, despite the Hospital's efforts and Request for Reconsideration, CLAIMS ADMINISTRATOR has not issued proper payment."

Amount in Dispute: $11160.98

Respondent's Position

"This bill was initially received by Claims Administrative Services on 6/2/2022 and was denied for timely filing on 6/22/2022. On 7/12/2022, we received a reconsideration, however no proof of timely was provided an actually confirms the bill was filed late. …It is our position that denial for timely filing was correct and no reimbursement would be due."

Response Submitted by: Claims Administrative Services, Inc

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 has expired
- 350 – Bill has been identified as a request for reconsideration or appeal
- 719 – Per Rule 133.20. A medical bill shall not be submitted 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 $11160.98 for outpatient hospital services rendered in November 2021. The insurance carrier denied the claim as no proof of 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 an exception to the timely filing requirement or that this claim was submitted within 95 days to the correct worker's compensation carrier. 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

Signature	Medical Fee Dispute Resolution Officer	December 13, 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 electronico CompConnection@tdi.texas.gov.