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
State Office of Risk Management

MFDR Tracking Number
M4-23-1164-01

Carrier's Austin Representative
Box Number 45

DWC Date Received
January 19, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 21, 2022	250	$3661.00	$0.00
April 21, 2022	278	$34687.00	$0.00
April 21, 2022	300	$228.00	$0.00
April 21, 2022	360	$29655.00	$0.00
April 21, 2022	370	$4118.00	$0.00
April 21, 2022	424	$394.00	$0.00
April 21, 2022	636	$6074.00	$0.00
April 21, 2022	710	$14048.00	$0.00
	Work Comp Adj	-78545.78	$0.00
	Total	$14,319.22	$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 State Office of Risk Management, but the bill was denied. The Hospital requested State Office of Risk Management review underpayment and issue payment. However, despite the Hospital's efforts and Request for Reconsideration, State Office of Risk Management has not issued payment."

Amount in Dispute: $14,319.22

Respondent's Position

"Upon receiving notification of the dispute submitted by the requestor Providence Memorial Hospital the Office has determined that the denial of 29-time limit for filing has expired and will be maintained."

Response Submitted by: State Office of Risk Management

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
- 193 – Original payment decision is being maintained upon review it was determined that this claim was processed properly

Issues

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

Findings

1. The requestor is seeking reimbursement of outpatient hospital services rendered in April 2022. The insurance carrier denied the claim for untimely submission.

   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.

The requestor included documentation to support a claim was submitted to the insurance carrier timely however, the claim was returned to the requestor on June 24, 2022 as the claim was incomplete.

DWC Rule 133.20 (g) states in pertinent part, health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier.

Review of the submitted documentation found the claim was corrected and resubmitted however it was not received by the insurance carrier until August 5, 2022. This receipt date is after the 95-day filing deadline.

Insufficient evidence was found to support the medical bill was submitted timely or that an exception to timely filing exists. The insurance carrier's denial is supported. 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

		March 7, 2023
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.