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

General Information

Requestor Name
Methodist Dallas Medical Center

Respondent Name
Liberty Insurance Corp

MFDR Tracking Number
M4-23-2109-01

Carrier's Austin Representative
Box Number 1

DWC Date Received
April 24, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 23 - 26, 2022	27822 LT	$12,438.73	$0.00
	Total	$12,438.73	$0.00

Requestor's Position

"Liberty Mutual denied the original bill and the appeal for timely filing. The bill was sent within timely filing. Please take the following facts into consideration when reviewing this fee dispute."

Amount in Dispute: $12,438.73

Respondent's Position

"The bill has been reviewed no payment is due at this time and the bill was denied correctly as the bill was not received within 95 days from Date of Service. The Date of Service for this treatment is 08/26/2022 and bill was submitted to Liberty Mutual on 12/13/2022 which is 109 days from Date of Service. Per Rule 133.20 (b) Except as provided in Labor Code 408.272(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 General Rules for Non-Division Communications.

3. 28 Texas Administrative Code §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:

- 4471 – Per Tx Labor Code Sec. §408.027 providers must submit bills to payors within 95 days of the date of service.

Issues

1. Is the requestor's position statement supported?
2. What rule(s) are applicable to submission of a medical claim?

Findings

1. The requestor is seeking reimbursement of outpatient hospital services rendered in August of 2022. The insurance carrier denied the claim for past timely filing. The requestor states in their position statement the claim was submitted timely.

   DWC Rule §102.4 (h) Unless the great weight of evidence indicates otherwise, written communications will be deemed to have been sent on:

   (1) the date received if sent by fax, personal delivery, or electronic transmission; or

   (2) the date postmarked if sent by mail through United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent must be the next previous day that is not a Sunday or legal holiday.

Review of the submitted documentation found insufficient evidence to support the requestor's position.

2. 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 as show 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

		May 30, 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.