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
VHS Brownsville Hospital

Respondent Name
Space Exploration Technologies Corp

MFDR Tracking Number
M4-23-2200-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
May 2, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 20, 2022	0250	2612.00	$0.00
June 20, 2022	0278	31026.00	$0.00
June 20, 2022	0300	1530.00	$0.00
June 20, 2022	0320	1984.00	$0.00
June 20, 2022	0360	45207.00	$0.00
June 20, 2022	0370	12604.00	$0.00
June 20, 2022	0636	3468.00	$0.00
June 20, 2022	0710	7560.00	$0.00
June 20, 2022	0730	952.00	$0.00
	WC ADJUSTMENTS	-95346.12	$0.00
	Total	$11674.88	$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 Corvel, but the bill was denied. However, despite the Hospital's efforts and Request for Reconsideration Corvel has not rendered proper payment."

Amount in Dispute: $11674.88

Respondent's Position

"Corvel has never received a medical bill from this Requestor for DOS 6/20/2022. The Requestor submitted a position statement indicating "The Hospital billed Corvel, but the bill was denied"; however, no Explanation of Benefits was provided to support this statement. The Requestor indicates they submitted the original bill to Corvel at a PO Box in Arlington, Texas. Corvel is not located in Arlington, Texas nor do we have a PO Box in that city. It is unclear to whom the bill was directed or who received the bill."

Response Submitted by: Corvel

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 §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

Neither party submitted an explanation of benefits that supports adjudication of the disputed medical bill.

Issues

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

Findings

1. The requestor is seeking reimbursement for outpatient hospital services rendered in June of 2022. The insurance carrier states a claim was not received. The following two rules apply to receipt of medical bills.

   DWC Rule 28 TAC §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.

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 in sufficient information to support that the medical bill was sent to the correct address of the workers' compensation carrier within the required time frame or that an exception to the filing deadline 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

	Peggy Miller	June 8, 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.