



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Valley Baptist Medical Center

Respondent Name

AIU Insurance Co

MFDR Tracking Number

M4-23-2911-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

July 18, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 14, 2022	70450	\$231.20	\$0.00
August 14, 2022	99285	\$1108.78	\$0.00
Total		\$1339.98	\$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of their reconsideration that states, "Occasionally circumstances beyond the control of our organization occur. Please note that the patient originally present as self-pay. The patient did not inform us that this was a worker's compensation claim until 12.12.2022. It was at this time, we received your information. Our claim was submitted to you on 12.23.2022 which is within the timely filing limit."

Amount in Dispute: \$1339.98

Respondent's Position

"It is the Respondent's belief that the Requestor did not submit documentation to support proof of timely filing. The Requestor indicates they were unaware the claim was a WC claim until 12-12-22. However, the Requestor has not submitted proof of that statement. To whom did the Requestor send the bill originally? The Requestor offered no valid proof as described in Sec. 408.0272 (above) for the original bill, nor the request for reconsideration."

Response Submitted by: CorVel Healthcare Corporation

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 \(TAC\) §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 denied the disputed services with the following claim adjustment codes.

- 29 – Time Limit for Filing Claim/Bill has Expired.
- RM2 - Time limit for filing claim has expired.
- 97A – Provider appeal

Issues

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

Findings

1. The requestor is seeking reimbursement for outpatient hospital services rendered in August 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 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(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 the respondent's statement that the claim was filed timely after notification of 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 requestor has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	August 3, 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 electrónico CompConnection@tdi.texas.gov.