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
Providence Sierra

Respondent Name
City of Midland

MFDR Tracking Number
M4-23-3264-01

Carrier's Austin Representative
Box Number 04

DWC Date Received
August 21, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 25, 2022	0250	$329.00	$0.00
October 25, 2022	0278	$52443.00	$0.00
October 25, 2022	0300	$610.00	$0.00
October 25, 2022	0360	$50332.00	$0.00
October 25, 2022	0370	$10382.00	$0.00
October 25, 2022	0636	$3413.00	$0.00
October 25, 2022	0710	$5326.00	$0.00
October 25, 2022	WC ADJUSTMENTS	-9903116	$0.00
	Total	$23,803.84	$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 ADMINISTRATOR, but the bill was denied. The Hospital requested CLAIMS ADMINISTRATOR to review this denial and issue proper payment. However, despite the Hospital's efforts and Request for Reconsideration, CLAIMS ADMINISTRATOR has not issued proper payment."

Amount in Dispute: $23803.84

Respondent's Position

"It is our position provider knew the correct carrier but the expenses were not filed timely, and our denial should be maintained."

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).

Statues 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 – The time limit for filing has expired.
- 719 – Per Rule 133.20, a medical bill shall not be submitted later than the 95th day after the date of service.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- W3 – In accordance with Rule 134.304, this bill has been identified as a request for reconsideration or 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 October of 2022. The insurance carrier denied the claim as not submitted timely. 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 the respondent's statement that the claim was filed timely after notification of the correct worker's compensation carrier address or that an exception described above 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 entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

		September 22, 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.