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 Hospital

**Respondent Name**
East Texas Educational Insurance Assoc.

**MFDR Tracking Number**
M4-23-3326-01

**Carrier's Austin Representative**
Box Number 17

**DWC Date Received**
August 29, 2023

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| February 9, 2022 | 320/71101 | Left blank | $0.00 |
| February 9, 2022 | 320/73030 | As above | $0.00 |
| February 9, 2022 | 320/73564 | As above | $0.00 |
| February 9, 2022 | 320/73564/76 | As above | $0.00 |
| February 9, 2022 | 450/96372 | As above | $0.00 |
| February 9, 2022 | 450/99284 | As above | $0.00 |
| February 9, 2022 | 636/j1100 | As above | $0.00 |
| | **Total** | $702.24 | $0.00 |

## Requestor's Position

The requestor did not submit a position statement with this request for MFDR but did submit a copy of their reconsideration that states, "We did not receive accurate insurance information at the time of service from your member and recently learned that you are the correct payor. The facility made a good faith attempt to file our claim for medically necessary services within the specified timeframe. Based on the extenuating circumstances outlined below, we have established sufficient cause for you to reverse your denial for untimely filing and pay the referenced claim(s) at this time. Once Hospitals of Providence East received updated insurance information on 4/25/22, the claim was then submitted to CLMS ADMINISTRATIVE on 5/2/22."

**Amount in Dispute:** $702.24

## Respondent's Position

"On 2/16/2022, Claims Administrative Services mailed the provider a request for copies of the medical records and bills. . . The bill was initially received on 6/2/2022 and on 6/17/2022 it was denied for timely filing. . . It is our position provider was notified where to file their medical bill, 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).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.

Denial Reasons

The insurance carrier denied the payment for 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 TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. The requestor is seeking payment for outpatient hospital services rendered on February 9, 2022. The insurance carrier denied the disputed services as not submitted timely.

   DWC Rule 28 TAC §133.307(c)(1) states:

   "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the division receives the request.

(A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

(B) A request may be filed later than one year after the date(s) of service if:

(i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability;

(ii) a medical dispute regarding medical necessity has been filed, the medical fee dispute must be filed not later than 60 days after the date the requestor received the final decision on medical necessity, inclusive of all appeals, related to the health care in dispute and for which the insurance carrier previously denied payment based on medical necessity; or

(iii) the dispute relates to a refund notice issued pursuant to a division audit or review; the medical fee dispute must be filed not later than 60 days after the date of the receipt of a refund notice.

The date of the service in dispute is February 9, 2022. The request for medical dispute resolution was received at the Division on August 29, 2023. This date is greater than one year from the date of service.

Review of the submitted documentation found insufficient evidence to support an exception as detailed above. The requestor has waived their right to MFDR.

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 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**

| | | |
|---|---|---|
| | | 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.