



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Providence Sierra

**Respondent Name**

Texas Mutual Insurance Co

**MFDR Tracking Number**

M4-24-0776-01

**Carrier's Austin Representative**

Box Number 54

**DWC Date Received**

December 6, 2023

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 15, 2022	0250	\$214.00	\$0.00
December 15, 2022	0278	\$62,853.33	\$0.00
December 15, 2022	0320	\$517.00	\$0.00
December 15, 2022	0360	\$84,272.00	\$0.00
December 15, 2022	0370	\$10,382.00	\$0.00
December 15, 2022	0636	\$3,623.00	\$0.00
December 15, 2022	0710	\$10,462.00	\$0.00
WC ADJUSTMENTS	WC ADJUSTMENTS	\$-76,630.73	\$0.00
		<b>Total</b>	<b>\$95,692.60</b>

### 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 TEXAS MUTUAL, but the bill was denied. The Hospital requested TEXAS MUTUAL to review this denial and issue proper payment as TEXAS MUTUAL'S insured provided incorrect information to the Hospital. However, despite the Hospital's efforts and several Requests for Reconsiderations sent to TEXAS MUTUAL on or about May 22, 2023, and again on December 4, 2023, TEXAS MUTUAL has not issued proper payment. The above reference claim is still denied and an amount of no less than \$95,692.60 is expected."

**Amount in Dispute:** \$95,692.60

## Respondent's Position

"In their position statement the requestor asserts that the injured worker provided the incorrect insurance information, however, Sierra Medical Center was in contact with Texas Mutual on 12/7/2022 to obtain out of network approval before treatment was rendered. Additionally, in the hospital records received with the medical bill, Texas Mutual is listed as the insurance carrier. Our position is that no payment is due."

**Response Submitted by:** Texas 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 \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §133.20](#) sets out requirements of medical bill submission.
3. [28 TAC §102.4](#) details the general rules for Non-Division Communication.
4. [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.

- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- CAC-W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC-193- Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- CAC-29 – The time limit for filing has expired.
- 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- D25 – Approved non-network provider for WorkWell, TX network claimant per rule 1305.153 (C)
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.

- 731 – Per 133.20(B) provider shall not submit a medical bill later than the 95<sup>th</sup> day after the date of service.

## Issues

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

## Findings

1. The requestor is seeking reimbursement of outpatient hospital services rendered in December of 2022. The insurance carrier denied the claim as not submitted within 95 days of the date of service.

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.

DWC finds there is insufficient information to support the disputed medical bill was submitted by the respondent within 95 days 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 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**

_____	_____	<u>December 21, 2023</u>
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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).