



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

TX Health Arlington

Respondent Name

Safety National Casualty Corp

MFDR Tracking Number

M4-25-0213-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

September 17, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 14, 2024	250	\$74.29	\$0.00
March 14, 2024	272	\$21.00	\$0.00
March 14, 2024	320	\$648.00	\$0.00
March 14, 2024	450	\$501.25	\$0.00
March 14, 2024	450	\$460.75	\$0.00
March 14, 2024	636	\$176.06	\$0.00
March 14, 2024	771	\$182.00	\$0.00
Total		\$2,063.35	\$0.00

Requestor's Position

"The initial claim was sent electronically 6/19/2024 and ZERO PAID, a reconsideration was 8/5/2024, per EOR, CLAIM DENIAL TIMELY FILING' which leaves a remaining balance of \$2063.35."

Amount in Dispute: \$2,063.35

Respondent's Position

"Absent the provider providing something more, the provider is not entitled to reimbursement because it failed to submit its initial medical bill to the Workers' Compensation carrier within 95 days of the date of service."

Response Submitted by: Flahive, Ogden & Latson

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. [The 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.
- W3 – Bill is a reconsideration or appeal.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 4271 – Per TX Labor Code Sec. 408.027, providers must submit bills to payors within 95 days of the date of service.

Issues

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

Findings

1. The requestor is seeking reimbursement of outpatient emergency room services. The insurance carrier denied the medical bill as not being submitted within 95 days.

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 submit a timely 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 the carrier indicated on the explanation of benefits the claim was received on June 19, 2024. This date is beyond 95 days from the date of service.

DWC finds there is insufficient information to support an exception described above. 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 requester is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	October 31, 2024
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.