



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

MHHS Katy Hospital

Respondent Name

Berkley National Insurance Co

MFDR Tracking Number

M4-25-1122-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

January 27, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 11 – 2024 to April 8, 2024	Occupational Therapy	\$6,875.00	\$0.00
Total		\$6,875.00	\$0.00

Requestor's Position

"This is a bill for services provided by Memorial Hermann Hospital for a workers comp injury for the above name patient. The bill was denied by the carrier for timely filing. However, per Texas Administrative Code Rule §133.20, we billed the carrier within 95 days of being informed by Sedgwick the carrier had changed."

Amount in Dispute: \$6,875.00

Respondent's Position

"The provider claims that it submitted the bill within 95 days of being informed by Sedgwick that the carrier had changed. Yet, the carrier never changed. The carrier has always been Berkeley National Insurance Company and it has always adjusted this file. Pursuant to § 408.027, the provider was required to submit the medical bill to the carrier within 95 days of the date of service. The provider failed to do so and as [as] offered no proof to the contrary. The provider is not entitled to any reimbursement."

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 explanation of benefits submitted with this dispute was for services rendered in July of 2024. Neither party submitted explanation of benefits from the disputed dates of service.

Issues

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

Findings

1. The requestor is seeking reimbursement of occupational therapy services rendered from March to April 2024. An explanation of benefits relevant to these services was not submitted at the time of MFDR.

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 a document titled "Jopari" Claim history report that references the disputed dates of service and the amount in dispute. However, this document does not support the submission of the medical bill to the correct worker's compensation carrier.

DWC finds there is insufficient information to support the requestor submitted the claim in a timely manner to the correct workers' compensation carrier at any time. 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 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

Signature

Medical Fee Dispute Resolution Officer

March 4, 2025
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.