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
Memorial Hermann Surgical

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-25-1139-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
January 28, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 25, 2024	29825	$6,100.33	$0.00
	Total	$6,100.33	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of a document titled "Reconsideration" that states, Please note that bill was submitted to Hartford Insurance prior to billing TX Mutual. We submitted all required documentation, including the billing and medical reports, along with proof of timely filing."

Amount in Dispute: $6,100.33

Respondent's Position

""The rationale given by the requestor for the late bill is not consistent with the Rule above. The documentation provided with the medical dispute is insufficient and/or illegible. 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).

Statues 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-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.
- CAC – 18 – Exact duplicate claim/service.
- 224 – Duplicate charge.

Issues

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

Findings

1. The requestor is seeking reimbursement outpatient hospital surgical services rendered in June of 2024. The insurance carrier denied the claim as not filed within ninety-five days from 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.

Review of the submitted documentation found a screen shot a "Query" screen from Unified Health Services. This document does not indicate what carrier the claim was submitted to or whether the claim was received by the correct workers' compensation carrier.

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 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

		March 4, 2025
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.