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
Baylor Surgical Hospital Las Colinas

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-25-1717-01

Carrier's Austin Representative
Box Number 45

DWC Date Received
March 31, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 30, 2024	99284	$723.06	$0.00
September 30, 2024	96372	$123.24	$0.00
	Total	$846.30	$0.00

Requestor's Position

"...at the time the patient presented to out ED, she gave her BCBS information. This claim was sent to BCBS. I have attached the EOB from BCBS showing that they received this claim 10/09/24. This is well within the 95 day time frame and considered acceptable proof that the claim was filed timely based on the information provided by the patient."

Amount in Dispute: $846.30

Respondent's Position

"Upon receiving notification of the dispute submitted by the requestor, Baylor Surgical Hospital Las Colinas, the Office reviewed the disputed charges and determined that we will maintain our denial. There is no evidence in the dispute packet to support the two criteria outlined in Texas Labor Code §408.0272(b), (c), or (d) to apply toward an exception to timely filing a medical bill within 95 days from the date of service."

Response Submitted by: SORM

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.

- W3 – Reporting purposes only.
- 29 – The time limit for filing has expired.

Issues

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

Findings

1. The requestor is seeking reimbursement outpatient emergency room services rendered in September of 2024. The insurance carrier denied the services as filed past 95 days from 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.

Review of the submitted documentation found evidence of a claim processed by BCBS on October 9, 2024, however, insufficient information to support that within 95 days of the notification of the claim being a workers' compensation claim that the requestor submitted the claim to the correct workers' compensation carrier as detailed 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

April 24, 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.