



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Dr. Glenn Bricken

Respondent Name

Federal Insurance Co

MFDR Tracking Number

M4-18-3854-01

Carrier's Austin Representative

Box Number 17

MFDR Date Received

June 8, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The charges referenced herein were filed with the Carrier and denied for "time limit for filing claim/bill has expired." ...We faxed both claims in accordance with timely filing. Please see the attached fax confirmations, claim printed dates from our billing system, and the disaster proclamation extending billing and reconsideration deadlines."

Amount in Dispute: \$450.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel asserts the requestor, Glenn Joseph Bricken is entitled to \$0.00 reimbursement for psych services in dispute based on the requestor's failure to request medical fee dispute resolution no later than one year after the date of service in dispute."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Rows include service dates from Dec 2016 to Feb 2017 and corresponding service numbers and amounts.

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical

services.

3. 28 Texas Administrative Code §102 defines communication dates.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 29 – The time limit for filing claim/bill has expired
 - 18 – Duplicate claim/service

Issues

1. Was the request for MFDR submitted timely?
2. Are the insurance carrier's reasons for reduction of payment supported?
3. What rule is applicable to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. Review of the submitted Medical Fee Dispute Request finds the date of service is December 6, 2016 and February 1, 2017. The request for MFDR was received June 8, 2018. This is outside the one year requirement. However, The Division's Commissioner issued Bulletin # B-0020-17 states in pertinent part, "For system participants who reside in the counties listed in the Governor's disaster proclamation, the Texas workers' compensation deadlines for the following procedures are tolled through the duration of the Governor's disaster proclamation:
 - Workers' compensation claim notification and filing deadlines
 - Medical billing deadlines
 - Medical and income benefit payment deadlines
 - Electronic data reporting deadlines, and
 - Medical and income benefit dispute deadlines

Review of the submitted medical bill found the zip code of 77380 in Montgomery County. This county is found within the "Proclamation by the Governor of the State of Texas" disaster declaration.

The tolled period or days not counted towards the filing deadline are calculated as follows. Date of service December 16, 2016 to the date of proclamation B-0020-17, August 23, 2017, is 261 days. The clock stopped at this point but began again on January 10, 2018 per proclamation B-0042-17. From January 10, 2018 to June 8, 2018 is 149 days for a total of 410 (261 + 149) days. Therefore, this date of service is untimely to MFDR and will not be considered in this review.

Date of service February 1, 2017 to the date of proclamation B-0020-17, August 23, 2017, is 204 days. The clock stopped at this point but began again on January 10, 2018 per proclamation B-0042-17. From January 10, 2018 to June 8, 2018 is 149 days for a total of 353 (204 + 149) days. Therefore, the requestor has not waived their right to MFDR for this date of service. The service in dispute will be reviewed per applicable rules and fee guidelines.

2. The requestor is seeking \$450.00 for professional medical services rendered on February 1, 2017. The carrier reduced the submitted billed amounts as 29 – "Time limit for filing claim/bill has expired and 18 – "Duplicate billing."

Review of the submitted documentation finds a fax confirmation of a medical bill for the date of service in dispute that was successfully faxed on February 6, 2017.

28 Texas Administrative Code §102.4 (h) states,

Unless the great weight of evidence indicates otherwise, written communications shall 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 via 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 shall be the next previous day which is not a Sunday or legal holiday.

Based on the above, the date of service February 1, 2017 was submitted timely and will be reviewed per applicable Division rules and fee guidelines.

3. 28 Texas Administrative Code §134.203 (c) states in pertinent part,

To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

- Procedure code 98037, billed February 1, 2017 has a MAR calculated as follows: $57.5/35.8887 \times \$126.20 = \202.19 .

4. The total allowable reimbursement for the services in dispute is \$202.19. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$202.19.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$202.19, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

_____	_____	August 10, 2018
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 in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.