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
M4-18-3855-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
June 8, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The charges reference herein were filed with the Carrier and denied, listing no reason codes or description. We have requested reconsideration from the carrier, and they have maintained the denial rational, stating the claim was a duplicate. The claim was faxed, timely, to the Carrier on 5/11/17 to the confirmed fax number for claims. The fax confirmation is attached."

Amount in Dispute: $225.00

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

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 4, 2017	90837	$225.00	$202.19

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 §133.240 sets out requirements for explanation of benefits.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 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 May 4, 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 which 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 date 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. However, the tolled period or days not counted towards the filing deadline are calculated as follows.

   Date of service May 4, 2017 to the date of proclamation B-0020-17, August 23, 2017, is 112 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 150 days for a total of 262 (112 + 150) 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 $225.00 for professional medical services rendered on May 4, 2017. The carrier reduced the submitted billed amounts as 18 – "Duplicate billing."

   Review of the submitted documentation found an explanation of benefits dated February 7, 2018 however this Explanation of Benefits contained no reduction reason.

   28 Texas Administrative Code 133.240 (f) states in pertinent part,

   The paper form of an explanation of benefits under subsection (e) of this section, §133.250 of this title (relating to Reconsideration for Payment of Medical Bills), or §133.260 of this title (relating to Refunds) shall include the following elements:

   (17) health care service information for each billed health care service, to include:

   (G) adjustment reason code that conforms to the standards described in §133.500 and §133.501 of this title if total amount paid does not equal total amount charged;

   (H) explanation of the reason for reduction/denial if the adjustment reason code was included under subparagraph (G) of this paragraph and if applicable;

   The division found insufficient evidence to support the requirements shown above were met on the EOB dated February 7, 2018 or the "duplicate" billing denial. The service in dispute 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 May 4, 2017 has a MAR calculated as follows: 57.5/35.8887 x $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.