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
MEMORIAL MRI & DIAGNOSTIC

Respondent Name
ACE AMERICAN INSURANCE COMPANY

MFDR Tracking Number
M4-18-4327-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
July 16, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 06/11/18 I receive a EOB with denial for timely filing. Please see attached and please reconsider bill and process for payment."

Amount in Dispute: $7,672.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel asserts the requestor . . . is entitled to $0.00 reimbursement for diagnostic 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	Dispute Amount	Amount Due
August 30, 2016	Professional Medical Services	$7,672.00	$0.00

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 §124.2 sets out requirements for carrier reporting and notification.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 219 – Based on Extent of Injury
   - 29 – Time Limit for Filing Claim/Bill has Expired
   - 97A – Provider appeal

Issues

1. Are there any outstanding issues related to compensability, extent of injury, or liability?
2. Has the requestor waived the right to medical fee dispute resolution for failure to timely file the MFDR request?

Findings

1. The insurance carrier denied disputed services with adjustment reason code 219 – "Based on Extent of Injury."

   However, upon reconsideration the insurance carrier did not maintain this denial reason.

   Neither did the respondent maintain this denial reason in their response to the request for MFDR.

   Nor did the respondent include copies with their response of any Plain Language Notice(s) regarding dispute over compensability, extent of injury or liability, as required by Rule §133.307(d)(2)(H) which states, "If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with §124.2 of this title."

   Accordingly, the division concludes there are no outstanding issues of compensability, extent of injury, or liability related to the disputed services. The disputed medical fee issues are therefore eligible for review.

2. The respondent asserts the requestor has waived the right to MFDR "based on the requestor's failure to request medical fee dispute resolution no later than one year after the date of service in dispute."

   28 Texas Administrative Code §133.307(c)(1) requires that a requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. Rule §133.307(c)(1)(A) further requires a request for MFDR, that does not meet certain exceptions listed in Rule §133.307(c)(1)(B), to be filed no later than one year after the date(s) of service in dispute.

   The date of the services in dispute is August 30, 2016. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on July 16, 2018. This date is later than one year after the date(s) of service in dispute.

   However, the requestor is located in Harris County. This was a county impacted by Hurricane Harvey and subject to the Governor's disaster proclamation of August 23, 2017. Pursuant to the Commissioner of Worker's Compensation Bulletin #B-0020-17, issued August 29, 2017, for system participants in affected counties, all deadlines with respect to claim notification and filing, medical billing, medical and income benefit payments, electronic data reporting, and medical and income benefit disputes are tolled (suspended) through the duration of the Governor's disaster proclamation. Pursuant to Commissioner's Bulletin # B-0042-17, the tolling period was lifted on January 10, 2018, with the effect that the 'clock' for making a required filing resumed 'ticking' on the effective date the tolling period ended.

   Review of the submitted documentation finds 358 days had transpired between the date of service (August 30, 2016) and the Governor's proclamation of August 23, 2017. An additional 187 days elapsed after expiration of the tolling period on January 10, 2018 until the filing of the dispute request with MFDR on July 16, 2018—for a total of 545 days. This is beyond the one-year filing limit provided in Rule §133.307(c)(1)(B); consequently, the division concludes the requestor has waived the right to request medical fee dispute resolution for the disputed services.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	September 7, 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.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.