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
Elite Healthcare Garland

Respondent Name
Service Lloyds Insurance Co

MFDR Tracking Number
M4-21-0964-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
February 22, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted documentation stating the exclusivity of the CPT's and requested they reprocess for payment in full. Service Lloyds insurance continues to deny payment for this patient's CPT99361 date of service."

Amount in Dispute: $113.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The previous review is being maintained."

Submitted by: Mitchell International Inc

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 7, 2020	99361	$113.00	$113.00

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 §134.204 sets out the reimbursement guidelines for workers' compensation specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – The time limit for filing has expired
   - 758 – Bill was not submitted timely in accordance with DWC Chapter 133

Issues

1. Is the insurance carrier's denial supported?
2. What Rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement of professional services rendered July 7, 2020. The insurance carrier denied the claim as past timely filing. The DWC Commissioner's Bulletin # B-0010-20 details the tolling of medical billing deadlines due to a catastrophic event that meet the requirements of Labor Code Section 408.0272(b)(2) effective March 25, 2020. As the disputed date of service is after the date of the bulletin, the service in dispute will be calculated per the applicable fee guideline.
2. 28 TAC §134.204 (e)(4)(A)(i) states in pertinent part CPT Code 99361 reimbursement shall be $113. This amount is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has established payment is due. As a result, the amount ordered is $113.00.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $113.00, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 12, 2021 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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 TAC §141.1(d).

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