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
MILLENNIUM CHIROPRACTIC

Respondent Name
MARKEL INSURANCE CO.

MFDR Tracking Number
M4-17-2799

Carrier's Austin Representative
Box Number 17

MFDR Date Received
May 18, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The chronic pain management services rendered during the dates of service . . . were pre-authorized by the carrier . . . approved by the insurance carrier for a cervical strain, and were performed in accordance with the ODG guidelines."

Amount in Dispute: $2,402.65

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor has treated a condition unrelated to the compensable injury and is not entitled to reimbursement."

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
September 28, 2015 to January 6, 2016	Functional Capacity Evaluation 97750-FC	$2,402.65	$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 §124.2 sets out requirements for carrier reporting and notification.
2. 28 Texas Administrative Code §124.3 sets out rules for investigating an Injury and giving notice of dispute.
3. 28 Texas Administrative Code §133.240 sets out requirements regarding medical payments and denials.
4. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
5. This request for medical fee dispute resolution was dismissed by the division's MFDR Section on June 29, 2017; however, the division withdrew that dismissal on July 11, 2017, reopening the dispute for review.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 107 – The related or qualifying claim/service was not previously paid or identified on this claim.
   - 850-202 – DENIED: PER CARRIER THIS TREATMENT IS NOT RELATED TO THIS WORKERS' COMPENSATION CLAIM. PLEASE CONTACT THE CLAIMANT FOR POSSIBLE ALTERNATE COVERAGE INFORMATION. $0.00

Issue

1. Are there unresolved issues of relatedness of the treatment to the workers' compensation claim?
2. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. The carrier denied disputed services with claim adjustment code 850-202 – DENIED: PER CARRIER THIS TREATMENT IS NOT RELATED TO THIS WORKERS' COMPENSATION CLAIM. PLEASE CONTACT THE CLAIMANT FOR POSSIBLE ALTERNATE COVERAGE INFORMATION.

   Rule §133.240(h) requires the insurance carrier to file notice as required by Labor Code §409.021 and Rules §124.2 and §124.3 if denying payment based on compensability of, liability for, or relatedness to the employee's injury.

   Rule §124.3(e) requires If a carrier receives a medical bill for treatments or services they believe are not related to the compensable injury, the carrier shall file a notice of dispute of extent of injury (notice of dispute) in accordance with Rule §124.2 (relating to Carrier Reporting and Notification) not later than the earlier of (1) the date the carrier denied the medical bill; or (2) the date for the carrier to pay or deny the medical bill as provided in Chapter 133.

   Rule §124.2(h) requires the carrier to notify the division and claimant of a dispute of extent of injury using plain language notices prescribed by the division. The notice must describe the action taken and reasons for doing so. The statement must contain sufficient claim-specific substantive information for the employee or beneficiary to understand the carrier's position or action. A simple, generic statement using phrases such as "not part of compensable injury," "liability is in question," "under investigation," "eligibility questioned" or similar phrases with no further description of the factual basis for the action taken does not satisfy the requirements of this rule.

   Rule §133.307(d)(2)(H) requires that if a medical fee dispute involves issues of compensability, extent of injury, or liability, the carrier shall attach to the MFDR response a copy of any related Plain Language Notice issued in accordance with Rule §124.2.

   Review of the insurance carrier's response packet finds the respondent did not attach copies of any PLN-11 or plain language notices issued in accordance with Rule §124.2, as required by Rule $133.307(d)(2)(H). The carrier has thus failed to meet the requirements of Rule §133.307(d)(2)(H) regarding properly asserting any issues of extent of injury or relatedness to the compensable injury and has waived the right to raise such issues at MFDR. Consequently, the above denial reason regarding relatedness is not supported.

   The division concludes there are no outstanding issues of liability, compensability or extent of injury. This dispute may therefore be considered for medical fee dispute resolution in accordance with division rules.

2. 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 medical fee dispute resolution (MFDR).

   Rule §133.307(c)(1)(A) further requires that a request for MFDR that does not meet any exceptions listed in Rule §133.307(c)(1)(B) be filed no later than one year after the dates of service in dispute.

   The disputed dates of service extend from September 28, 2015 to January 6, 2016. The request was received in the division's MFDR Section on May 18, 2017. This date is later than one year after the dates of service.

   Rule §133.307(c)(1)(B)(i) provides that a request may be filed later than one year after the date(s) of service if a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed. However, as found above, there are no outstanding issues of compensability, extent of injury, or liability related to the disputed services, and the requestor has not filed any related dispute under Chapter 410. Accordingly, the division finds the request does not meet any of the exceptions listed in Rule §133.307(c)(1)(B).

   The division's MFDR section received this request on May 18, 2017. This date is beyond the one-year time limit for filing the MFDR request. Consequently, the division concludes the requestor failed to timely request medical fee dispute resolution. The requestor has therefore waived the right to MFDR for these services.

Conclusion

The division emphasizes that the findings in this decision are based on the evidence presented by the requestor and respondent available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons stated above, the division finds the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

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	November 16, 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.