



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

INDEMNITY INSURANCE COMPANY
OF NORTH AMERICA

MFDR Tracking Number

M4-18-0212-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

September 25, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "because the carrier did not file a 'notice of dispute' against the patient's conditions actually treated by our clinic, the carrier's '*Charge unrelated to the compensable injury*' denial on their EOBs would be considered a generic statement with no substance or understanding of the carrier's position for the denial of payment... THE CARRIER IS ALSO CLEARLY GUILTY OF 'withdraw(ing) a preauthorization ... approval (after it was) issued.'"

Amount in Dispute: \$13,200.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the Hearing Officer determines that ... extent of injury does not include the disputed conditions. The Hearing Officer also specifically determines that Dr. VanderWerff's treatment and services provided are NOT related to the compensable injury. Therefore, the Carrier is not liable for benefits."

Response Submitted by: Quintairos, Prieto, Wood & Boyer, P.A.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 11, 2014 to January 21, 2015	Chronic Pain Management	\$13,200.00	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §102.3 sets out rules for computation of due dates and time.
- 28 Texas Administrative Code §102.5 sets out rules for communication to and from the division.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - W-12 – CHARGE UNRELATED TO THE COMPENSABLE INJURY (TX07)
 - This procedure on this date was previously reviewed (148)
 - Duplicate claim/service. (ANSI18)
 - 219 – Based on extent of injury. (ANSI219)
 - 29 – The time limit for filing has expired. (ANSI29)

Issue

Did the requestor waive the right to medical fee dispute resolution?

Findings

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 November 11, 2014 to January 21, 2015. The request was received in the division's MFDR Section on September 25, 2017. This date is later than one year after the dates of service.

However, the insurance carrier denied disputed dates of service with reason codes:

- W-12 – CHARGE UNRELATED TO THE COMPENSABLE INJURY (TX07)
- 219 – Based on extent of injury. (ANSI219)

These denial reasons involve issues of compensability, extent of injury or liability.

Rule §133.307(c)(1)(B)(i) provides that an MFDR request may be filed *later* than one year after the dates of service if a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed. The medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability.

A contested case hearing was held to determine whether the disputed services relate to the compensable injury. A decision and order resolving issues of compensability, extent of injury or liability was issued on October 26, 2016. After Appeals Panel review, the hearing officer's decision was affirmed and became final on February 22, 2017.

Rule §102.5(d) provides that to determine the date of receipt for written communications sent by the division that require the recipient to perform an action by a specific date after receipt, unless the great weight of evidence indicates otherwise, the division shall deem the received date to be the earliest of: five days after the date mailed via United States Postal Service regular mail; the first working day after the date the written communication was placed in a carrier's Austin representative box; or the date faxed or electronically transmitted.

The hearing officer's decision became final after Appeals Panel review on February 22, 2017. Five days after that date was Monday, February 27, 2017. Accordingly, the division deems February 27, 2017 to be the date the requestor received the final decision in the Chapter 410 dispute. Pursuant to Rule §133.307(c)(1)(B)(i) above, the 60-day period to file an MFDR request ended on Friday, April 28, 2017. The requestor was thus required to file the MFDR request no later than April 28, 2017 or waive the right to fee dispute.

The division's MFDR section received this MFDR request on September 25, 2017. This date is beyond the time limit for filing the MFDR request as extended by the medical provider's receipt of the final decision on the matters of compensability, liability and extent. 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

Signature

Grayson Richardson
Medical Fee Dispute Resolution Officer

November 2, 2018
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.