TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Dismissal

General Information

Requestor Name
Robert Joseph Coolbaugh, DC

Respondent Name
Lubbock County

MFDR Tracking Number
M4-22-0995-01

Carrier's Austin Representative
Box Number 43

DWC Date Received
January 25, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 23, 2021	CPT Code 99080 (126 pages)	$63.00	$63.00
	Total	$63.00	$63.00

Requestor's Position

"Please review the attached CMS 1500, notes, and assignment of benefits, after reviewing please forward to the auditing department for payment processing."

Amount in Dispute: $63.00

Respondent's Position

The Austin carrier representative for Lubbock County is JI Specialty Services. JI Specialty Services received a copy of this medical fee dispute on February 1, 2022. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information

As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §404.155(a-b), requires providers to provide copies of medical records to the Office of Injured Employee Counsel (OIEC).
3. 28 TAC §134.120 outlines the reimbursement guideline for copies of medical records.

Denial Reasons

The insurance carrier [reduced or denied] the payment for the disputed services with the following claim adjustment codes:

- 242-According to the fee schedule, this charge is not covered.
- 06-Non-covered charge(s).
- N569-Not covered when performed by the reported diagnosis.
- CO-The amount adjusted due to a contractual obligation between the provider and the payor. It is not the patient's responsibility under any circumstances.
- The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 2005-No additional reimbursement allowed after review of appeal/reconsideration.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3-Bill is a reconsideration or appeal.
- OA-The amount adjusted is due to bundling or unbundling of services.

Issues

1. Is Lubbock Counties denial of payment based upon non-covered charges supported?
2. Is the requestor entitled to reimbursement for copies of medical records sent to the Office of Injured Employee Counsel?

Findings

1. The requestor is seeking dispute resolution for $63.00 for CPT code 99080 (126 pages) rendered on November 23, 2021.

   The respondent denied reimbursement based upon "06-Non-covered charge(s)," "N569-Not covered when performed by the reported diagnosis," and "242-According to the fee schedule, this charge is not covered."

   28 TAC § 133.307(d)(2)(H) 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 (relating to Carrier Reporting and Notification Requirements)."

   The DWC finds the respondent did not file a PLN-11 in accordance with §124.2 disputing the diagnosis; therefore, the DWC finds the respondent did not support this dispute involves compensability, extent of injury, or liability.

2. Based upon the submitted medical bills, the requestor billed CPT code 99080 – special reports or copies of reports, for 126pages, on the disputed date of service. The requestor noted that the copies of medical records were for the Office of Injured Employee Counsel.

   Texas Labor Code §404.155(a-b), states "(a) At the written request of an ombudsman designated under this subchapter who is assisting a specific injured employee, a health care provider shall provide copies of the injured employee's medical records to the ombudsman at no cost to the ombudsman or the office.

   (b) The workers' compensation insurance carrier is liable to the health care provider for the cost of providing copies of the employee's medical records under this section. The insurance carrier may not deduct that cost from any benefit to which the employee is entitled."

   Based upon the submitted documentation, the requestor complied with Texas Labor Code §404.155(a) and submitted 126 pages of medical records to the Office of Injured Employee Counsel; therefore, reimbursement for the copies of medical records is recommended.

   28 TAC §134.120(f), states "The reimbursements for medical documentation are: (1) copies of medical documentation--$.50 per page." Therefore, 126 pages X $.50 = $63.00. The respondent paid $0.00. The difference between amount due and paid is $63.00.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that reimbursement of $63.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Lubbock County must remit to Robert Joseph Coolbaugh, DC $63.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	04/13/2022 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.