



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

BALDWIN CHIROPRACTIC

Respondent Name

NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number

M4-17-0772-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

November 18, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "[injured employee's] insurance company has refused to pay for . . . care and any injury other than . . . left shoulder."

Amount in Dispute: \$3,541.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor did not comply with Division Rules with respect to appropriate billing codes, and . . . is not entitled to reimbursement of the bills as they are currently submitted. The Division Rules require Medicare program reimbursement methodologies, 28 Tex. Admin. Code § 134.202(b) [sic], but Requestor submitted its claim using Washington state-specific CPT codes, instead of Medicare program CPT codes. . . . Carrier also asserts that the dispute, with respect to the dates of service from September 10, 2015 through November 10, 2015 was not timely filed because Requestor filed the claim greater than one year from the dates of service at issue."

Response Submitted by: Brown Sims

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Dispute Amount, Amount Due. Row 1: September 10, 2015 to September 27, 2016, Chiropractic Services, \$3,541.30, \$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 §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §133.10 sets out requirements for billing forms and formats.

## Issues

1. Under what authority is this request for medical fee dispute resolution considered?
2. Did the health care provider timely submit a request for medical fee dispute resolution?
3. Did the health care provider present copies of explanations of benefits to MFDR for the disputed services?
4. Did the health care provider submit the medical bills to the

## Findings

1. The requestor is a health care provider that rendered disputed services in the state of Washington to an injured employee subject to a Texas Workers' Compensation insurance claim. The health care provider has requested medical dispute resolution in accordance with Texas Labor Code Section 413.031(a)(1), which entitles a health care provider to a review of medical services if payment is reduced or denied. Because the requestor has sought the administrative remedy provided in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the Division concludes it has jurisdiction to decide the medical fee issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable 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 MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) . . .

(A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

The dates of the services in dispute include September 10, 2015 to September 27, 2016. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on November 18, 2016. The postmark date is November 15, 2016. This date is later than one year after the dates of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in Rule §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section with regard to disputed dates of service September 10, 2015 to November 13, 2015 consequently, the requestor has waived the right to medical fee dispute resolution for those disputed services. However, the dispute with regard to service dates from November 16, 2015 to September 27, 2016 was timely received by the division and thus those services are eligible for review.

3. Rule §133.307(c)(2)(K) requires that the health care provider must include with the request for medical fee dispute resolution "a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal. . . ."

Review of the submitted documentation finds no copies of any explanations of benefits with regard to disputed dates of service November 16, 2015 to September 27, 2016.

The health care provider did not provide convincing evidence of carrier receipt of the request for an EOB.

4. 28 Texas Administrative Code §133.10 details the division requirements for the required billing forms and formats for submission of medical bills to an insurance carrier.

28 Texas Administrative Code §134.203(b) further requires that for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

- (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers . . . and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

Review of the medical bills submitted by the health care provider finds that the services were billed using Washington state codes for the disputed services. The services as billed do not meet the required billing formats for Texas Workers' Compensation participants as specified in Rule §133.10, nor did the provider use CPT or HCPCS billing codes as specified by Medicare payment policies as required in Rule §134.203(b).

Accordingly, the division concludes that the requestor has failed to support that the medical bills were ever presented to the insurance carrier in the form and format as specified by division rules and Medicare payment policies. Additional payment cannot be recommended.

**Conclusion**

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The Division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has failed to establish that additional reimbursement is due. As a result, the amount ordered is \$0.00.

**ORDER**

Based on the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

**Authorized Signature**

\_\_\_\_\_  
Signature

Grayson Richardson  
Medical Fee Dispute Resolution Officer

August 18, 2017  
Date

**YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 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 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 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 with the Division. **Please include a copy of the *Medical Fee Dispute Resolution 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.**