



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

Maddox Chiropractic Clinic

Respondent Name

Accident Fund Insurance Co of America

MFDR Tracking Number

M4-17-2503-01

Carrier's Austin Representative

Box Number 6

MFDR Date Received

April 21, 2017

REQUESTOR'S POSITION

Requestor's Position: Requestor asserts that the services in dispute did not require preauthorization; that the injured employee was referred to him by an adjuster for the carrier; and that he and the injured employee were not timely notified by the carrier that change in treating doctor was required.

Amount in Dispute: \$13,905.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Accident Fund cannot confirm whether bills were ever received for any or all of the disputed dates of service because the original bills and any requests for reconsideration are not attached to the request. Further, there is no indication in the request that reconsideration was ever requested under the provisions of Rule 133.250...dates before 4-21-16 are outside the one year from the date of service and cannot be considered."

Response Submitted by: Stone Loughlin Swanson 3508 Far West Blvd Suite 200 Austin TX 78731

SUMMARY OF FINDINGS

Dates of Service	Findings	Amount In Dispute	Amount Due
April 16, 2016 through April 19, 2016	Filed to medical fee dispute resolution after the one year filing deadline. The right to fee dispute for these services is waived.		
April 20, 2016 through April 21, 2016	No evidence of reconsideration before filing for medical fee dispute resolution – Not eligible for review	\$216.00	\$0.00
April 28, 2016 through April 19, 2017	No convincing evidence that services were billed to the carrier before medical fee dispute resolution	\$12,923.00	\$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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.250 sets out the procedures for reconsideration for payment of medical bills.
3. Dates of Service April 16, 2016 through April 21, 2016:
Explanation of Benefits Dated May 9, 2016
 - 243 – Services not authorized by primary care provider
 - 293 – This procedure requires prior authorization and none was identified
 - 309 – The charge for this procedure exceeds the fee schedule allowance
 - 5088 – Provider not authorized to treat
 - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
 - P12 – Workers compensation jurisdictional fee schedule adjustment
4. Date of service April 28, 2016 through April 19, 2017
 - No explanations of benefits were provided
 - No convincing documentation providing evidence of insurance carrier receipt of the medical bill or a request by the provider for an EOB

Findings

The medical fee dispute resolution program resolves disputes over payment of medical bills. Health care providers are responsible taking certain actions **before** filing for medical fee dispute resolution. These actions include, but are not limited to: (1) billing the carrier for the services; (2) asking the carrier for reconsideration of the final action taken by the carrier on the originally filed medical bills; and (4) allowing the carrier 30 days to respond to the request for reconsideration. The health care provider has the burden to prove that it took these actions before filing for medical fee dispute resolution. Otherwise, the fee dispute may not be eligible for review under the Division's medical fee dispute resolution process.

Additionally, health care providers waive the right to medical fee dispute resolution if the dispute is filed after the Division's one year filing deadline.

1. Maddox Chiropractic Clinic has waived the right to medical fee dispute resolution for dates of service April 16, 2016 – April 19, 2016. 28 Texas Administrative Code §133.307(c)(1) states, in pertinent part that a requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. Rule §133.307(c)(1)(A) further states that fee disputes filed later than one year **after** the date(s) of service in dispute are untimely. This medical fee dispute was received on April 21, 2017 which is past the filing deadline. Because Maddox Chiropractic Clinic waived its right to fee dispute resolution, these services will not be reviewed.
2. Maddox Chiropractic Clinic has failed to prove that it sought reconsideration for April 20, 2016 – April 21, 2016 prior to filing this medical fee dispute. Consequently, these dates are not eligible for review by the Division's medical fee dispute resolution program. The requirement for health care providers to seek reconsideration of a medical bill **before** filing for fee dispute resolution is found at 28 Texas Administrative Code §133.250 which states, in pertinent part, that if the health care provider is dissatisfied with the insurance carrier's final action on a medical bill **after reconsideration**, the health care provider may then request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills). Absent any evidence from the requestor that reconsideration was sought, the Division finds that these services are not eligible for review. Consequently, payment for these services cannot be recommended.
3. Maddox Chiropractic Clinic failed to provide evidence that it initially billed the carrier, or that the carrier received a complete medical bill for dates of service April 28, 2016 through April 19, 2017 before the filing of this medical fee dispute. The requirement to provide proof of original billing, proof of the carrier's final action, and proof of a request for reconsideration forms the basis for an adjudication under 28 Texas

Administrative Code §133.307. The requirement for the health care provider to include such evidence is plainly stated on Page 3 Division's Form DWC-060:

What documentation is required when filing the DWC Form-060?
The required documentation of disputed services that must accompany the request for medical fee dispute resolution varies depending on the type of entity requesting medical fee dispute resolution as set forth in 28 Texas Administrative Code (TAC), §133.307. See the chart below for guidance for specific types of requesters. In addition, all requesters except injured employees must complete the *Table of Disputed Services*.

Health Care Provider or Pharmacy Processing Agent
<ul style="list-style-type: none">• A paper copy of all medical bills related to the dispute• A paper copy of all medical bills submitted to the insurance carrier for reconsideration• A paper copy of each explanation of benefits (EOB) related to the dispute (or convincing evidence that the insurance carrier received the request for EOB)• A copy of the final decision regarding compensability, extent of injury, liability and/or medical necessity for the health care related to the dispute, if applicable• A copy of all applicable medical records related to the dates of service in dispute• A position statement of the disputed issues in accordance with 28 TAC §133.307(c)(2)(N)• If the dispute involves health care for which the TDI-DWC has not established a maximum allowable reimbursement or reimbursement rate, documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate in accordance with 28 TAC §134.1 or §134.503, as applicable• A signed and dated copy of the agreement between the agent and the pharmacy (applies only to pharmacy processing agent)• Other documentation the requester believes is applicable to the medical fee dispute

Maddox Chiropractic Clinic's failure to provide basic evidence in turn leaves no dispute, denial or payment for the Division to adjudicate. For that reason, reimbursement cannot be recommended.

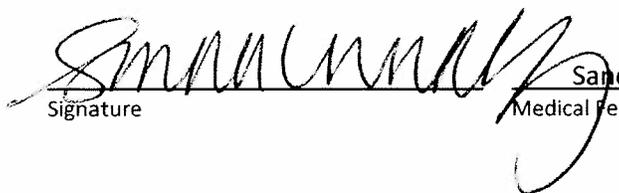
Conclusion

For the reasons stated above, the Division finds that the requestor has not established that no 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

Sandra Hernandez
Medical Fee Dispute Resolution Officer

8-10-2017
Date

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 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. **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.