



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Robert J. Coolbaugh, D.C.

**Respondent Name**

ACE American Insurance Company

**MFDR Tracking Number**

M4-24-1695-01

**Carrier's Austin Representative**

Box Number 15

**DWC Date Received**

April 8, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 13, 2024	99080 Copies of medical records	\$466.50	\$466.50
<b>Total</b>		\$466.50	\$466.50

### Requestor's Position

"Please review the attached CMS1500, notes, assignment of benefits, after reviewing please forward to the auditing department for payment processing."

**Amount in Dispute:** \$466.50

### Respondent's Position

"ESIS Med Bill Impact's Bill Review Department reviewed the above mentioned date of service and found that the provider was not due additional money. It has been determined that ESIS Med Bill Impact will stand on the original recommendation of \$0. Provider did not bill with correct modifier on report request and did not provide appropriate DWC form for reimbursement of copy services."

**Response Submitted by:** ESIS

## Findings and Decision

### Authority

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

### Statutes and Rules

1. 28 Texas Administrative Code [\(TAC\) §133.305](#) sets out the procedures for resolving medical disputes.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
3. 28 TAC §134.120 sets out the fee guidelines for copies of medical records.
4. 28 TAC §276.11 sets out the guidelines for providing documentation to the Office of Injured Employee Counsel.
5. Texas Labor Code §404.155 sets out the requirements for providing documentation to the Office of Injured Employee Counsel.

### Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- 1 – Original DCN 511521876; Request for reconsideration reviewed. No further payment recommended. Please submit a copy of the report and the bill for our review. The appropriate modifier was not utilized.
- 2 – This procedure on this date was previously reviewed (1148)
- 3 – 18 - Duplicate claim/service. (ANSI18)
- 1 – DWC form required.
- 2 – Please submit a copy of the report and the bill for our review.
- 3 – The appropriate modifier was not utilized. (4021)
- 4 – 16 - Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 5 163 – Attachment/other documentation referenced on the claim was not received. (ANSI1631)
- 6 252 – Attachment/other documentation is required to adjudicate this claim/ service. (ANSI252)
- 7 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing. (ANS14)
- B N714 – Missing report. (RARC�"/14)

## Issues

1. Is Robert J. Coolbaugh, D.C. entitled to additional reimbursement?
2. What is the recommended reimbursement amount for this dispute?

## Findings

1. A review of the submitted documentation indicates that Dr. Coolbaugh billed \$466.50 for 933 pages of medical records supplied to the Office of Injured Employee Counsel.

TLC 404.155, effective June 15, 2007, states:

(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.

(c) The amount charged for providing copies of an injured employee's medical records under this section is the amount prescribed by rules adopted by the commissioner for copying medical records.

Per 28 TAC §276.11, which was adopted to implement TLC 404.155, states "A health care provider's reimbursement from an insurance carrier for costs of documentation provided to OIEC are prescribed by the provisions of §134.120 of this title."

DWC finds that Dr. Coolbaugh is entitled to reimbursement for the services in question.

2. Reimbursement for copies of medical records is calculated at \$.50 per page according to 28 TAC §134.120 (f)(1). The CMS-1500 indicated that the charges were for 933 pages at \$.50/page results in an amount of \$466.50. Dr. Coolbaugh is seeking \$466.50. This amount is recommended.

## 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.

The DWC finds the requestor has established that reimbursement is due.

## Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the respondent must remit to the requestor \$466.50 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

\_\_\_\_\_  
August 2, 2024

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](http://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, call CompConnection at 1-800-252-7031, option 3 or email [CompConnection@tdi.texas.gov](mailto: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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).