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

# Medical Fee Dispute Resolution Findings and Decision

## General Information

**Requestor Name**
Bryce R Kindley DC

**Respondent Name**
Safety National Casualty Corp

**MFDR Tracking Number**
M4-25-2224-01

**Carrier's Austin Representative**
Box Number 19

**DWC Date Received**
May 13, 2025

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| September 24, 2024 | 99213 | $185.89 | $185.89 |
| September 24, 2024 | 99080-73 | $0.00 | $185.89 |
| October 9, 2024 | 99213 | $185.89 | $185.89 |
| October 24, 2024 | 99213 | $185.89 | $185.89 |
| October 24, 2024 | 99080-73 | $15.00 | $15.00 |
| November 13, 2024 | 99213 | $12.00 | $12.00 |
| November 13, 2024 | 99080-73 | $15.00 | $0.00 |
| November 27. 2024 | 99213 | $185.89 | $185.89 |
| November 27, 2024 | 99080-73 | $15.00 | $15.00 |
| December 9, 2024 | 99213 | $185.89 | $185.89 |
| December 9, 2024 | 99080-73 | $15.00 | $15.00 |
| January 13, 2024 | 99213 | $185.89 | $185.89 |
| January 13, 2024 | 99080-73 | $15.00 | $15.00 |
| January 29, 2025 | 99213 | $7.90 | $7.90 |
| January 29, 2025 | 99080-73 | $0.00 | $0.00 |
| | **Total** | $1210.44 | $1195.24 |

## Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy a reconsideration request dated March 13, 2025 and May 13, 2025 that states, "**AFTER**

**RECONSIDERATION WE WERE PAID IN FULL. AND SOME IN PARTIAL AND SOME NOT AT ALL. ALL THESE BILL SHOULD BE PAID IN FULL PER CCH ORDER.**"

**Amount in Dispute:** $1,210.44

## Respondent's Position

"Since the services rendered in the underlying matter were deemed not reasonable nor necessary by the reviewer, reimbursement was denied. Additionally, Texas Admin. Code § 133.10(f) sets out the required medical billing formats and required data. Texas Admin Code (f)(1) requires the employer's name and address to be listed (Boxes 4 & 7). The provider incorrectly listed this information on each and every bill submitted. As the Requestor failed to provide the required elements of the medical bills, the Requestor did not submit a complete medical bill for the services within the statutory time limit."

**Response submitted by:** White Espey PLLC

## 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. 28 TAC §133.240 requirements of medical bill processing/audit by insurance carrier.
3. TLC §19.2003 sets out the requirements of utilization review.
4. 28 TAC §134.203 sets out the reimbursement guidelines for professional medical services.

Denial Reasons

- 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer.
- W3 – Bill is a reconsideration or appeal.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 5072 – Treatment is not reasonable, necessary or causally related to the work injury.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment be made for the above noted procedure code.

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 5270 – Claim denied because this is not a work related injury/illness and thus not the responsibility of the workers compensation carrier.
- 131 – Claim specific negotiated discount.
- 190 – Billing for report and/or record review exceeds reasonableness.
- 272 – Service reviewed per client instructions.
- 8507 – Denied per adjuster instructions.
- 18 – Exact duplicate claim/service.
- 247 – A payment or denial has already been recommended for this service.

Issues

1. Did the respondent raise a new issue?
2. Did the carrier follow the appropriate administrative process in denying the services at no reasonable and necessary?
3. Was the required P11 notice submitted?
4. What is the rule applicable to reimbursement?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor states in the response to MFDR, "…the Requestor failed to provide the required elements of the medical bills, the Requestor did not submit a complete medical bill for the services within the statutory time limit."

   The DWC §133.307(d)(2)(F) states in pertinent part, "The responses shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review

   A review of the submitted EOB does not support the denial based upon incomplete bill or timely filing. As a result, due to the insufficient documentation the DWC will proceed with the audit of the disputed charges.

2. The insurance carrier denied the disputed charges with several denial reasons, including not reasonable nor necessary which was also included in the respondent's position statement.

   DWC Rule 28 Texas Administrative Code §133.240 (q) states, in relevant part, "When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title ... Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care

services, the insurance carrier shall comply with the requirements of §19.2010 of this title …, including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor ..."

Submitted documentation does not support that the insurance carrier followed the appropriate procedures for a retrospective review denial of the disputed services outlined in §19.2003 (b)(31) or §133.240 (q). Therefore, the insurance carrier did not appropriately raise medical necessity for this dispute and this denial reason will not be considered in this review.

3. The submitted explanation of benefits included a denial based on extent/relatedness. DWC Rule 28 TAC §133.307(d)(2)(H) requires that 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 Rule §124.2 (relating to carrier reporting and notification requirements).

   DWC Rule 28 TAC §124.2(h) requires notification to the division and claimant of any dispute of disability or extent of injury using plain language notices with language and content prescribed by the division. Such notices "shall provide a full and complete statement describing the carrier's action and its reason(s) for such action. The statement must contain sufficient claim-specific substantive information to enable the employee/legal beneficiary to understand the carrier's position or action taken on the claim."

   Review of the submitted information finds no copies, as required by Rule §133.307(d)(2)(H), of any PLN-11 or PLN 1 notices issued in accordance with Rule §124.2. The insurance carrier's denial reason is therefore not supported.

   Furthermore, because the respondent failed to meet the requirements of Rule §133.307(d)(2)(H) regarding notice of issues of extent of injury, the respondent has waived the right to raise such issues during dispute resolution.

   Consequently, the division concludes there are no outstanding issues of compensability, extent, or liability for the injury. The disputed services are therefore reviewed pursuant to the applicable rules and guidelines

4. DWC Rule 28 Texas Administrative Code §134.203(c)(1) states, "…To determine to MAR for professional services, system participants shall apply the Medicare payment policies with minimal modification…For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $53.68…"

   The following formula represents the calculation of the DWC MAR at §134.203 (c)(1) & (2).

   (DWC Conversion Factor ÷ Medicare Conversion Factor) x Medicare Payment = MAR. In this instance, 67.81/33.2875 x $91.25 (fee schedule allowable Garland, TX) for 2024 = $185.89.

   The maximum allowable reimbursement for the disputed dates of service are as follows.

   - Date of service September 24, 2024. The MAR is $185.89 the carrier paid $0.00. $185.89 is due for this date of service.

- October 9, 2024. The MAR is $185.89 the carrier paid $0.00. $185.89 is due for this date of service.
- October 24, 2024. The MAR is $185.89 the carrier paid $0.00. $185.89 is due for this date of service.
- November 13, 2024. The MAR is $185.89 the carrier paid $158.89. The requestor seeks an additional $12.00 for the disputed charge. This amount is recommended.
- November 27, 2024. The MAR is $185.89 the carrier paid $0.00. $185.89 is due for this date of service.
- December 9, 2024. The MAR is $185.89 the carrier paid $0.00. $185.89 is due for this date of service.

(DWC Conversion Factor ÷ Medicare Conversion Factor) x Medicare Payment = MAR. In this instance, 70.18/32.3465 x $89.32 (fee schedule allowable Garland, TX) for 2025 = $193.79.

- January 13, 2025. The MAR is $193.79 the carrier paid $7.90. $185.89 is due for this date of service.
- January 29, 2025. The MAR is $193.79 the carrier paid $185.89. $7.90 is due for this date of service.

The requestor is also seeking $15.00 for code 99808-73 for the following dates of service.

DWC Rule 129.5 (e)(g)(J) state in pertinent parts,

(e) The doctor, delegated physician assistant, or delegated advanced practice registered nurse shall file the Work Status Report:
(1) after the initial examination of the injured employee, regardless of the injured employee's work status;
(2) when the injured employee experiences a change in work status or a substantial change in activity restrictions; and
(1) on the schedule requested by the insurance carrier, its agent, or the employer requesting the report through its insurance carrier, which shall not exceed one report every two weeks and which shall be based upon the doctor's, delegated physician assistant's, or delegated advanced practice registered nurse's scheduled appointments with the injured employee.

(g) In addition to the requirements under subsection (e) of this section, the treating doctor, delegated physician assistant, or delegated advanced practice registered nurse shall file the Work Status Report with the insurance carrier, employer, and injured employee within seven days of the day of receipt of:
(1) functional job descriptions from the employer listing available modified duty positions that the employer is able to offer the injured employee as provided by §129.6(a) of this title (relating to Bona Fide Offers of Employment); or
(2) a required medical examination doctor's Work Status Report that indicates that the injured employee can return to work with or without restrictions.

(j) …The amount of reimbursement shall be $15. A doctor, delegated physician assistant, or

delegated advanced practice registered nurse shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section.

- October 24, 2024. Carrier denied for reasonableness. Insufficient evidence submitted to support the denial. The fee schedule allowable of $15.00 is recommended.
- November 13, 2024. Carrier supported payment of $15.00 made on March 11, 2025. No additional payment is recommended.
- November 27, 2024. The fee schedule allowable of $15.00 is recommended.
- December 9, 2024. Carrier denied by adjuster instruction. Insufficient evidence submitted to support the denial. The fee schedule allowable of $15.00 is recommended.
- January 13, 2025. The fee schedule allowable of $15.00 is recommended.

5. The total allowable DWC fee guideline reimbursement is $1,195.24. 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.

DWC finds the requester has established that additional reimbursement 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 Safety National Casualty Corp must remit to Safety National Casualty Corp $1,195.24 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

**Authorized Signature**

| | | |
|---|---|---|
| | | June 10, 2025 |
| Signature | Medical Fee Dispute Resolution Officer | 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.