Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DR FREDRICK KERSH
PO BOX 130757
TYLER TX 75713-0757

Respondent Name
Texas Mutual Insurance Co

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-12-2475-01

MFDR Date Received
March 26, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As treating Dr. we complete the 73 to extend the restrictions, etc for the injured employee. This is a time consuming process for the office and doctor. If we did not complete, the employer would expect the patient back at regular duty etc. we would receive multiple phone calls. There is a change."

Amount in Dispute: $15

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "When the requestor completes a DWC-73 inconsistent with the criteria of Rule 129.5 no payment should be issued and no be expected."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 17, 2011	Professional Services	$15.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 §129.5 sets out the procedures for reimbursement for work status reports.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   1. 85 – COVERAGE/PROGRAM GUIDELINES WERE NOT MET OR WERE EXCEEDED
   2. 18 – DUPLICATE CLAIM/SERVICE
   3. 248 – DWC-73 IN EXCESS OF THE FILING REQUIREMENTS: NO CHANGE IN WORK STATUS AND/OR RESTRICTION: REIMBURSEMENT DENIED PER RULE 129.5
   4. 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED

THAT THIS CLAIM WAS PROCESSED PROPERLY.

Issues

1. Did the respondent support the denial of the service in dispute?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service as "DWC-73 IN EXCESS OF THE FILING REQUIREMENMTS: NO CHANGE IN WORK STATUS AND/OR RESTRICTION: REIMBURSEMENT DENIED PER RULE 129.5. 28 Texas Administrative Code 129.5(a)(2) states, "substantial change in activity restrictions" means a change in condition which either prevents the employee for working under the previous restrictions or which allows the employee to work in an expanded and more strenuous capacity than the prior restrictions permitted (approaching the employee's normal job); (3) "change in work status" means a change in the employee's work status… (A) Allows the employee to return to work without restrictions; (B) allows the employee to a return to work with restrictions; or (C) prevents the employee from returning from work." 28 TAC 129.5(d)(2) states in pertinent part, The doctor shall file the Work Status Report; when the employee experiences a change in work status or a substantial change in activity restrictions…" Review of the DWC 73 shows no substantial change in work status or a substantial change in activity restrictions. The carrier's denial is supported.
2. Review of the submitted documentation finds that the requestor submitted a claim for filing DWC 73 to extend the restrictions in place however provisions outlined in 28 TAC 129.5 are not met as there was no substantial change in activity restrictions and no change in work restrictions, therefore additional payment cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon 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 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February , 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.