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
William D. Strinden, MD

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-12-2574-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
April 9, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Insurance will not pay for DWC 73 which was completed and attached initially to electronic claim Dr Strinden was a referring doctor and did not have access to any previous DWC 73 forms NOR was he ever contacted by adjuster with previous work status. He communicated on the form the status of the patient and also referred the work status rating to the treating doctor… The form was filled out because the patient indicated she needed it for her employer…"

Amount in Dispute: $15.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office … will maintain our denial …

The Office reviewed the DWC 73 … filed by the provider and found that it does not meet the criteria set forth by Rule §129.5. The provider failed to complete Part II (c) with the dates and a rationale on how the *worker's compensation injury* is preventing the employee from returning to work …"

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 23, 2012	Work Status Report (99080-73)	$15.00	$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 §129.5 sets out the procedures for Work Status Reports.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
   - 17 – Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.
   - Remittance Advice Remark: Per the incompleted attached DWC-73 report indicating work status will be determine by treating doctor.
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.
   - Remittance Advice Remark: The original DWC 73 submitted with BCN 2911084 missing information. Both dates are required in section II C.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code "17 – Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate." The insurance carrier further clarified the denial with remittance advice remarks, "Per the incompleted attached DWC-73 report indicating work status will be determine by treating doctor," and "The original DWC 73 submitted with BCN 2911084 missing information. Both dates are required in section II C."

   28 Texas Administrative Code §129.5 (i) states, in relevant part, "Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing **a complete Work Status Report** required under this section…" A complete Work Status Report is defined in §129.5 (c), which states, "The doctor shall be considered to have filed a complete Work Status Report if the report is filed in the form and manner prescribed by the Commission, signed, and contains at minimum: (1) identification of the employee's work status; (2) effective dates and estimated expiration dates of current work status and restrictions (an expected expiration date is not binding and may be adjusted in future Work Status Reports, as appropriate, based on the condition and progress of the employee); (3) identification of any applicable activity restrictions; (4) an explanation of how the employee's workers' compensation injury prevents the employee from returning to work (if the doctor believes that the employee is prevented from returning to work); and (5) general information that identifies key information about the claim (as prescribed on the report)."

   Review of the submitted information finds that the Work Status Report file with the insurance carrier did not meet the criteria for a complete Work Status Report. Therefore, the insurance carrier's denial reason is supported. Additional reimbursement 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

	Laurie Garnes	June 4, 2015
Signature	Medical Fee Dispute Resolution Officer	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 MFDR 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 this *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.