



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

G. PETER FOOX, MD

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-13-3147-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

JULY 26, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Rule 404.155 applies."

Amount in Dispute: \$25.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor was asked by OIEC to supply medical records to an ombudsman assisting the claimant. The requestor provided the records and now seeks reimbursement from Texas Mutual. Rule 134.120(c) states, '...Upon request, the health care provider shall provide the injured employee, or the injured employee's representative, an initial copy of the medical documentation without charge. The requestor shall reimburse the health care provider for subsequent requests of the same medical documentation.' The representative in this instance is the claimant's ombudsman. Further, the requestor has not shown it has already provided the documents and is seeking reimbursement for a subsequent request. No payment is due."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 25, 2013	CPT Code 99080 – Copies of Medical Records (19 pages)	\$25.00	\$9.50

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- Texas Labor Code §404.155, effective June 15, 2007 outlines the cost for certain copies.
- 28 Texas Administrative Code §134.120 titled *Reimbursement for Medical Documentation* effective May 2, 2006 sets out the fees for medical documentation
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CAC-4-The procedure code is inconsistent with the modifier used or a required modifier is missing.
 - 732-Accurate coding is essential for reimbursement. Modifier billed incorrectly or missing. Services are not

reimbursable as billed.

- 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 284-No allowance was recommended as this procedure has a Medicare status of 'B' (Bundled).
- CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 724-No additional payment after a reconsideration of services.

Issues

Is the requestor entitled to reimbursement for copies of medical records sent to the Office of Injured Employee Counsel?

Findings

Based upon the submitted medical bills, the requestor billed CPT code 99080 – special reports or copies of reports, for 19 pages, on the disputed date of service. The requestor noted that the copies of medical records were for the Office of Injured Employee Counsel.

Texas Labor Code §404.155(a-b), states “(a) At the written request of an ombudsman designated under this subchapter who is assisting a specific injured employee, a health care provider shall provide copies of the injured employee's medical records to the ombudsman at no cost to the ombudsman or the office.

(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.”

Based upon the submitted documentation, the requestor complied with Texas Labor Code §404.155(a) and submitted 19 pages of medical records to the Office of Injured Employee Counsel; therefore, reimbursement for the copies of medical records is recommended.

28 Texas Administrative Code §134.120(f), states “The reimbursements for medical documentation are: (1) copies of medical documentation--\$.50 per page.” Therefore, 19 pages X \$.50 = \$9.50. The respondent paid \$0.00. The difference between amount due and paid is \$9.50.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$9.50.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$9.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

12/12/2014

Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §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 MDR decision shall deliver a copy of the request 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 §141.1(d).

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