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
Robert E Urrea, MD

Respondent Name
Travelers Indemnity Co

MFDR Tracking Number
M4-13-1067-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
December 28, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is our position that procedure code 99080 should be allowed as per DWC Rule 134.120 (f)(5) and (g)."

Amount in Dispute: $100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider alleges they provided a report at the request of the Carrier. This is both true and misleading. The Carrier requested the Provider to determine whether the Claimant was at MMI, and if so to provide a report and DWC-69 to the Carrier. As the Provider determined the Claimant was not at MMI, no report to that effect was requested by the Carrier. Consequently, as the report was not requested by the Carrier and the Provider did not complete a DWC -69 determining the Claimant was not at MMI, no reimbursement is due for the services at issue."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 28, 2012	99080	$100.00	$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 §134.120 sets out guidelines for reimbursement for medical documentation.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - TX05 – Payment for this service is bundled into the payment for other services not specified.

Issues

1. Did the requestor support the disputed services are eligible for payment?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as, "TX05 – "Payment for this service is bundled into payment for other services not specified." 28 Texas Labor Code §134.120(g) states in pertinent part, "Narrative reports are defined as original documents explaining the assessment, diagnosis, and plan of treatment for an injured employee written or orally transcribed and created at the written request of the insurance carrier or the Division. Narrative reports shall provide information beyond that required by prescribed medical reports and/or records. A narrative report should be single spaced on letter-size paper or equivalent electronic document format. Clinical or progress notes do not constitute a narrative report." Review of the submitted physician's response letter dated September 28, 2012 did not contain a diagnosis or treatment. Also, in the review it was found the provider did not complete requested form from the carrier. The carrier's denial is supported.
2. Requirements of Division rules not met. No additional payment can 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	June 19, 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.