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
William Strinden MD

Respondent Name
Indemnity Insurance Co of North

MFDR Tracking Number
M4-13-2439-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
May 23, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Rule 129.5 specifically states the work status forms do not have to be attached to claims if they were previously sent. The form was sent via fax on 9/12/12 and we have fax confirmation. The insurer is responsible for sending them on to their 3rd party billing company. The billing company refuses to pay for the form and refuses to refer to rule 129.5"

Amount in Dispute: $15.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Request has failed to provide information that would substantiate the reason and circumstances under which the Work Status Report DWC-73 form was completed and that would demonstrate that it is entitled to reimbursement under Rule 129.5, Subsection (1) provides that a provider "shall not bill or be entitled to reimbursement for Work Status Report which is not reimbursable under this section."

Response Submitted by: Flahive Ogden & Latson, P.O. Box 201329 Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 12, 2012	99080 – 73	$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 guidelines for filing Work Status Reports
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 5247 – Description not available
   - 5261 – Description not available
   - 16 – Claim/service lacks information which is needed for adjudication

Issues

1. Did the requestor support basis for filing work status report?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service as, 16 – "Claim/service lacks information which is needed for adjudication." 28 Texas Labor Code §129.5(d) and (f) state in pertinent part, "The doctor shall file the Work Status Report: (1) after the initial examination of the employee, regardless of the employee's work status; (2) when the employee experiences a change in work status or a substantial change in activity restrictions; and (3) on the schedule requested by the insurance carrier (carrier), its agent, or the employer requesting the report through its carrier, which shall not to exceed one report every two weeks and which shall be based upon the doctor's scheduled appointments with the employee. (f) In addition to the requirements under subsection (d), the treating doctor shall file the Work Status Report with the carrier, employer, and 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 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 employee can return to work with or without restrictions." Review of the submitted documentation found nothing to indicate the circumstances from which the report was filed. The carrier's denial is supported.
2. The supporting documentation did not meet the requirements of 28 Texas Labor Code §129.5. No additional reimbursement 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	Peggy Miller Medical Fee Dispute Resolution Officer	June 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.