



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

JOSE TREVINO, MD

Respondent Name

ARCH INSURANCE CO

MFDR Tracking Number

M4-15-1472-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

JANUARY 20, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please note that records pertaining to this claim were requested by the Office of Injured Employee Counsel. This bill is submitted in accordance with Texas Administrative Code 276.11."

Amount in Dispute: \$64.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Supplemental response will be provided once the bill auditing company has finalized their review."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 8, 2014	CPT Code 99080 (129) Copies of Medical Records	\$64.50	\$64.50

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(a-b), requires providers to provide copies of medical records to the Office of Injured Employee Counsel (OIEC).
- 28 Texas Administrative Code §134.120 outlines the reimbursement guideline for copies of medical records.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 16-Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
 - BL-This bill is a reconsideration of a previously reviewed bill. Allowance amounts do not reflect previous payments.
 - B12-Services not documented in patients' medical records.
 - BL-CV Reconsideration no additional allowance recommended. This bill and submitted documentation have been re-evaluated by clinical validation. Submitted documentation.

- BL-Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, or the providers PPO contract.

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 33 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 129 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, 129 pages X \$.50 = \$64.50. The respondent paid \$0.00. The difference between amount due and paid is \$64.50.

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 \$64.50.

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 \$64.50 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

03/27/2015
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.