



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

American Zurich Insurance Co

MFDR Tracking Number

M4-15-3371-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

June 11, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "You denied payment for the form stating that it was bundled into another service. However DWC rule 134.120b specifically states that the insurance carrier shall separately reimburse subsequent copies of medical documentation requested by the insurance company."

Amount in Dispute: \$3.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: January 26, 2015, 99080, \$3.00, \$3.00

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 §134.120 sets out the guidelines for reimbursement of medical documentation.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." Review of the submitted documentation finds;
 - a. Document dated, "01-26-2015" Subject: Request for Medical Records
 - b. Above document was from Sharda Randolph of, Zurich North America Claims
 - c. Message stated, "Requesting medical records for (claimant's) middle finger injury. This is a work related injury. Fax all records to claims adjuster: Sharda Randolph."

28 Texas Administrative Code §134.120 (b) states, "An insurance carrier shall separately reimburse subsequent copies of medical documentation requested by the insurance carrier in accordance with §133.210 of this title." The Division finds the carrier's denial is not supported as a request was made for copies of the medical record.

2. 28 Texas Administrative Code §134.120 (f) states, "The reimbursements for medical documentation are: (1) copies of medical documentation--\$.50 per page;" The submitted medical claims show six units of 99080 for a total amount of \$3.00. This amount is recommended.
3. The total allowable reimbursement is \$3.00. This amount is recommended.

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 \$3.00.

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 \$3.00 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

July 28, 2015

Date

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, 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 MFDR 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.