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
ALEX GLOGAU, MD
ORTHOTEXAS PHYSICIANS AND SURGEONS

Respondent Name
GREAT MIDWEST INSURANCE CO

MFDR Tracking Number
M4-16-1600-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
FEBRUARY 9, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This bill is for a medical narrative completed by Dr. Glogau after requested by Wendy Bozzell at the OIEC."

Amount in Dispute: $100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 16, 2015	CPT Code 99080 Copies of Narrative Report	$100.00	$100.00

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. Texas Labor Code §404.155(a-b), requires providers to provide copies of medical records to the Office of Injured Employee Counsel (OIEC).
3. 28 Texas Administrative Code §134.120 outlines the reimbursement guideline for copies of medical records.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - RC05-The value of the procedure is included in the value of another procedure performed on this date.
   - TX97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - RC@G-No additional reimbursement allowed after review of appeal/reconsideration.
   - TTW3-Level 2 appeal means a request for reimbursement under 133.250.
   - TXW3-Additional payment made on appeal/reconsideration.

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 bill, the requestor billed CPT code 99080 for a medical narrative report requested by the OIEC on the disputed date of service.

The respondent denied reimbursement for the narrative report based upon reason codes "RC05, and TX97." A review of the submitted medical bill and explanation of benefits, finds that the requestor did not bill for any other service on the disputed date of service; therefore, the respondent's denial is not supported.

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 OIEC requested the disputed narrative report. The requestor complied with Texas Labor Code §404.155(a) and submitted a one page narrative to the OIEC.

28 Texas Administrative Code §134.120(f)(5)(A), states "The reimbursements for medical documentation are: (5) narrative reports: (A) one to two pages--$100;." Therefore, the requestor is due $100.00. The respondent paid $0.00. The difference between amount due and paid is $100.00.

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 $100.00.

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 $100.00 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	March 24, 2016 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.