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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ORTHOTEXAS PHYSICIANS AND SURGEONS

MFDR Tracking Number
M4-17-1709-01

MFDR Date Received
February 6, 2017

Respondent Name
WC SOLUTIONS

Carrier's Austin Representative
Box Number 19

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The OIEC requested a medical testimony to prove causation. Se the attached documentation that supports the services provided. Please reprocess this claim for payment immediately."

Amount in Dispute: $100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The narrative report was provided to the OIEC and not the TDI-DWC or the carrier; therefore, this is a non-covered charge."

Response Submitted by: STARR Comprehensive Solutions, Inc.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
September 28, 2016	Medical Narrative (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 the procedures and reimbursement for medical documentation.
3. Texas Labor Code §404.002 establishes the Office of Injured Employee Counsel administrative attachment.
4. Texas Labor Code §404.101 defines the general duties of the Office of Injured Employee Counsel.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 96 – Non-covered charge(s)
   - 96 – Per rule 134.120(e) the health care provider shall provide copies of any requested or required documentation to the Division at no charge.

Issue(s)

1. Is WC Solutions responsible for reimbursement of the service in question?
2. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement in the amount of $100.00 for a medical narrative, billed under CPT Code 99080 and rendered on September 28, 2016. Medical narratives are subject to the requirements of 28 Texas Administrative Code §134.120, which states, in relevant part, "(d) If the injured employee, or the injured employee's representative, requests creation of medical documentation, such as a medical narrative, the requestor shall reimburse the health care provider for this additional information."

   The documentation submitted by the requestor includes a copy of a letter dated September 14, 2016, requesting the medical narrative in question. The letter is on the Office of Injured Employee (OIEC) letterhead and signed by an ombudsman. Texas Labor Code §404.002(b) administratively attaches the office to the division, but specifies that the office is independent of the division. For this reason, the letter does not constitute a request from the division per 28 Texas Administrative Code §134.120(e).

   Texas Labor Code §404.101(b) (2) (C) states that OIEC shall "assist injured employees, through the ombudsman program, in the division's administrative dispute resolution system." The division concludes that the injured employee requested the medical narrative with the assistance of OIEC in accordance with Texas Labor Code §404.101(b) (2) (C). Therefore, per 28 Texas Administrative Code §134.120(d), the insurance carrier is not responsible for the reimbursement of the disputed service.
2. The Division finds that the requestor is not entitled to reimbursement for the disputed service rendered on September 28, 2016. As a result, $0.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that 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	March 10, 2017 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.