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
REYNOLDS, IAN JOHN

Respondent Name
Property and Casualty Insurance of Hartford

MFDR Tracking Number
M4-20-1695-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
March 9, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The treating physician is required to send medical documentation to the designated doctor per Texas Labor Code 408.0041(c), therefore we complied and submitted 133 pages at .50 a page =$66.50. This charge is not bundled to any other service. Service is payable in the State of Texas."

Amount in Dispute: $66.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider references 28 TAC §134.120(c), However, this rule does not contain a provision that the carrier is liable for copy charges for reports forwarded to the Designated Doctor, therefore, the carrier upholds denial."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 3, 2020	Medical Documentation (99080)	$66.50	$66.50

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 (DWC).

Background

1. 28 Texas Administrative Code §127.10 sets out the rules for submitting documentation to designated doctors.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.120 sets out the fee guidelines for medical documentation.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer.

- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 243 – The charge for this procedure was not paid since the value of the procedure is included/bundled within the value of another procedure performed.
- 274 – Service is not reimbursable for workers' compensation injuries in this state.
- W3 – Additional payment on appeal/reconsideration.

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. Is Ian J. Reynolds, M.D., P.A. entitled to reimbursement for the service in question?

Findings

1. Dr. Reynolds is seeking reimbursement for copies of documents sent to a designated doctor by order of the DWC.

   In Texas, the DWC requires the treating doctor to send copies of all medical documents related to the injury being evaluated by a designated doctor.[1] The same rules states, "The cost of copying shall be reimbursed in accordance with §134.120 of this title."No provision provides that this service is subject to medical necessity or bundling denials.

   Therefore, the DWC finds that the insurance carrier's reasons for denial of payment are not supported.

2. Because the insurance carrier's denial of payment for the service in dispute, Dr. Reynolds is entitled to reimbursement. Medical documentation is reimbursed at $0.50 per page.[2]

   Dr. Reynolds billed for 133 pages. The insurance carrier did not dispute the claimed number of units billed. The DWC finds that Dr. Reynolds is entitled to reimbursement of $66.50 for the disputed service.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $66.50.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requestor $66.50, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	April 1, 2020
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 TAC §127.10 (a)(1)
[2] 28 TAC §134.120 (f)(1)

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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. **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.