



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

DEEPAK V. CHAVDA MD, PA

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-14-3143-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

JUNE 16, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Procedure code 99080 Special Report/Work Status DWC-73 was denied in error as 'no change in work status and/or restrictions.'... **Services were approved by Adjustor Phyllis**... Last work status report was done on 09/17/2013 for this patient."

Amount in Dispute: \$25.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed Texas Mutual for providing a DWC-73 form to the benefits administrator.... Upon receipt of the billing Texas Mutual staff reviewed the DWC-73, found no change in the work status, and denied payment. The requestor alleges the benefits administrator requested the DWC-73. Texas Mutual reviewed the claim file and found no request in December for a DWC-73. Texas Mutual spoke with the benefits administrator who indicated a DWC-73 was requested in October for a September DWC-73. It appears the requestor is mistaken as to the time frame involved and also misinterpreted the benefits administrator's request in October, i.e. the request was limited to September and did not mean monthly submissions of the DWC-73 regardless of no change in work status. No payment is due."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 10, 2013	CPT Code 99080-73 Work Status Report	\$25.00	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.204, effective March 1, 2008, sets out medical fee guidelines for workers' compensation specific services.
- 28 Texas Administrative Code §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports The services in dispute were reduced/denied by the respondent with the following reason

codes:

- CAC-W1-Workers compensation state fee schedule adjustment.
- CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 248-DWC-73 in excess of the filing requirements; no change in work status and/or restrictions; reimbursement denied per rule 129.5.
- CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Was CPT code 99080-73 billed in accordance with 28 Texas Administrative Code §129.5? Is the requestor entitled to reimbursement for CPT code 99080-73?

Findings

CPT code 99080-73 is defined as “Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form.”

28 Texas Administrative Code §134.204 (l) states “The following shall apply to Work Status Reports. When billing for a Work Status Report that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section, refer to §129.5 of this title (relating to Work Status Reports).”

28 Texas Administrative Code §129.5(i)(1) states “Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be \$15. A doctor shall not bill in excess of \$15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section.”

28 Texas Administrative Code §129.5 (d)(1) and (2) states “The doctor shall file the Work Status Report:

(1) after the initial examination of the employee, regardless of the employee's work status;

(2) when the employee experiences a change in work status or a substantial change in activity restrictions.”

The respondent submitted a copy of the report that does not indicate a change in claimant’s work status in accordance with 28 Texas Administrative Code §129.5 (d)(1) and (2); therefore, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional 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

03/25/2015

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.