TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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AMENDED
MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
WILLIAM STRINDEN, MD

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-18-5082

Carrier's Austin Representative
Box Number 45

MFDR Date Received
AUGUST 21, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am requesting payment for the work status form filled out at the initial visit."
Amount in Dispute: $15.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Review of the requestor's submissions of the DWC 73, the requestor has failed to include in Part III, a restriction as stated in Box 16 which states 'continue present restrictions until 6/18/2018'."
Response Submitted By: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 4, 2018	CPT Code 99080-73 Work Status Report	$15.00	$0.00

AMENDED FINDINGS AND DECISION

This **amended** decision supersedes the previous decision issued on September 14, 2018. 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 §134.239, effective July 7, 2016, sets out medical fee guidelines for workers' compensation specific services.
3. 28 Texas Administrative Code §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - P13, 6549-Payment recued or denied based on Workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable.
   - 16-Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.

- W3-Additional payment made on appeal/ reconsideration.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues
Is the requestor entitled to reimbursement for the work status report?

Findings
28 Texas Administrative Code §129.5 states that a doctor may bill for, and a carrier shall reimburse, filing a *complete* Work Status Report.

An incomplete work status report is not reimbursable.

Rule §129.5(c) defines a complete work status report as one that contains:
(1) the identification of the employee's work status;
(2) the effective dates and estimated expiration dates of current work status and restrictions (an expected expiration date is not binding and may be adjusted in future Work Status Reports, as appropriate, based on the condition and progress of the employee);
(3) the identification of any applicable activity restrictions;
(4) an explanation of how the employee's workers' compensation injury prevents the employee from returning to work (if the doctor believes that the employee is prevented from returning to work); and
(5) general information that identifies key information about the claim (as prescribed on the report).

We compared the work status report (DWC Form-073) signed by Dr. Strinden to the requirements of §129.5(c) and found, in pertinent part:
- that Dr. Strinden allowed the injured employee to return to work "with the restrictions identified in Part III";
- no specific restrictions were identified in Part II; and
- Part III, box 16. Simply stated "continue present restrictions."

The service in dispute is not reimbursable because Dr. Strinden's notations do not support that this was an initial work status report. Instead, the notation under box 16 indicates that this was a subsequent report without a change in restrictions which is not reimbursable.[1]

In the alternative, if we consider that the report in dispute describes the injured employee's initial work status, then the report is not complete because it did not contain the rationale necessary for all the parties involved to fully understand the restrictions.[2]

Conclusion
For the reasons stated above, the Division finds that the requestor has not met his burden to prove that the disputed amount is due. As a result, the amount ordered is $0.00.

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[1] Adoption preamble for Rule §129.5 published in the March 10, 2000 issue of the *Texas Register* (25 TexReg 1975) states "Comment: In response to opposition to reimbursement for the report expressed at the public hearing, a commenter offered a compromise proposal that would allow for reimbursement of the form but limit the increase in costs by allowing the initial report to be reimbursed and any subsequent report which reports a change in work status. Under this compromise, subsequent reports that simply report that the employee's work status had not changed would not be reimbursed since the report would be easier to fill out."
[2] Adoption preamble for Rule §129.5 published in the March 10, 2000 issue of the *Texas Register* (25 TexReg 1975) states "In order to address the issue of 'completeness,' the Commission has changed subsections (b) and (c)… Subsection (i) was also amended to indicate that doctors are only entitled to reimbursement when a report is complete."

ORDER

The undersigned has been delegated authority by the Commissioner of the Division of Workers' Compensation to sign this official order. This amended order supersedes the previous order issued on September 14, 2018.

For the reasons stated, the amount ordered is $0.00.

Authorized Signature

		October 5, 2018
Signature	Medical Fee Dispute Resolution Director	Date

RIGHT TO APPEAL

Either party to this medical fee dispute may seek review of this Division decision. To appeal, submit form DWC Form-045M titled ***Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)*** found at https://www.tdi.texas.gov/forms/form20numeric.html.

Follow the instructions on pages 3 and 4. The request must be received by the division within twenty days of your receipt of this decision. This decision becomes final if the request for review of a this decision is not timely made.

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.

If you have questions about the DWC Form-045M, please call CompConnection at 1-800-252-7031, Option 3 or you may email your question to CompConnection@tdi.texas.gov

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, Option 1.