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

GENERAL INFORMATION

Requestor Name
LUFKIN PLASTIC SURGERY

Respondent Name
DEEP EAST TEXAS SELF INSURANCE CO

MFDR Tracking Number
M4-19-4487-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
JUNE 12, 2019

REQUESTOR'S POSITION SUMMARY

"I am writing to request payment for the work status form that was requested by Jacquelyn Maxwell, senior claims examiner on April 1, 2019 for the office visit on 02/04/2019. The form was faxed to her on 04/02/19 and the fax confirmation shows that it was received at 3:40pm. It is the responsibility of the insurer to share reports with other departments and third party reviewers. Each time the form is sent the doctor is allowed to charge $15.00."

Amount in Dispute: $15.00

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
February 4, 2019	CPT Code 99080-73-RR Work Status Report	$15.00	$15.00

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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.239, effective July 7, 2016, sets out medical fee guidelines for workers' compensation specific services.

3. 28 TAC §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - 18-Exact duplicate claim/service.
   - 247-A payment or denial has already been recommended for this service.
   - 5041-In order to appropriately review the submitted date of service, the office notes/report or medical records are needed and requested for review.

Issues

Is the requestor due reimbursement for a copy of the DWC-73 form sent to the respondent?

Findings

1. The Austin carrier representative for Deep East Texas Self Insurance Co is White Espey, PLLC. White Espey, PLLC acknowledged receipt of the copy of this medical fee dispute on June 20, 2019. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

   As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

2. The requestor is seeking medical fee dispute resolution in the amount of $15.00 for CPT code 99080-73-RR rendered on February 4, 2019. The requestor contends reimbursement is due because, "I am writing to request payment for the work status form that was requested by Jacquelyn Maxwell, senior claims examiner on April 1, 2019 for the office visit on 02/04/2019. The form was faxed to her on 04/02/19 and the fax confirmation shows that it was received at 3:40pm."

3. The respondent denied payment based upon "16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication," and "5041-In order to appropriately review the submitted date of service, the office notes/report or medical records are needed and requested for review."

4. A review of the submitted documentation finds a copy of a work status report dated February 4, 2019.

5. The following statute is applicable to the disputed services:

   - 28 TAC §134.239 states, "When billing for a work status report that is not conducted as a part of the examinations outlined in §134.240 and §134.250 of this title, refer to §129.5 of this title."

   - 28 TAC §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."

6. The DWC reviewed the submitted documentation and finds the following:

   - The requestor billed $15.00 for CPT code 99080-73-RR dated February 4, 2019.
   - The requestor wrote that the respondent requested a copy of the report and it was faxed on April 1, 2019.
   - Per 28 TAC §129.5(i)(1), the requestor is due reimbursement of $15.00.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $15.00.

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 DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of $15.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		12/05/2019
Signature	Medical Fee Dispute Resolution Officer	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 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 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 DWC. **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.