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
STEVEN SIMMONS, DO, PLLC

Respondent Name
CITY OF FORT WORTH

MFDR Tracking Number
M4-19-5259-01

Carrier's Austin Representative
Box Number 04

MFDR Date Received
August 23, 2019

Response Submitted By
No response received from insurance carrier

REQUESTOR'S POSITION SUMMARY

"the dates that the employee has to be off work for the injury DID CHANGE… Without filing this report, the doctor would not have a way to report the date change."

RESPONDENT'S POSITION SUMMARY

The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
July 16, 2019	Work Status Report 99080-73	$15.00	$15.00

AUTHORITY

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §129.5 sets out the requirements and reimbursement for work status reports.
3. The insurance carrier denied payment for the disputed service with claim adjustment code:
   - P13 – PAYMENT REDUCED OR DENIED BASED ON WORKERS' COMPENSATION JURISDICTIONAL REGULATIONS OR PAYMENT POLICIES

Findings

The Austin carrier representative for the City of Fort Worth is the Law Office of Ricky D. Green, whose agent acknowledged receipt of a copy of the MFDR request on August 30, 2019.

28 Texas Administrative Code §133.307(d)(1) provides that if the division does not receive a response within 14 calendar days of dispute notification, the division may base its decision on the available information. To date, no response has been received. Consequently, this decision is based on the information available at the time of review.

The insurance carrier denied payment for the disputed services with the following claim adjustment code:

- P13 – PAYMENT REDUCED OR DENIED BASED ON WORKERS' COMPENSATION JURISDICTIONAL REGULATIONS OR PAYMENT POLICIES

With additional payment comment:

> Per Rule 129.5(d)(2) [sic] The doctor shall file the Work Status Report when the employee experiences a change in work status or a substantial change in activity restrictions. Based on review of the attached Work Status Report and previously filed report(s) there is no evidence of a change in work status or a substantial change in activity restrictions to warrant reimbursement in accordance with Division rules.

28 Texas Administrative Code §129.5(e)(2) **r**equires a provider to file the Work Status Report "when the injured employee experiences a change in work status or a substantial change in activity restrictions."

The requestor asserts, "the dates that the employee has to be off work for the injury DID CHANGE"

The insurance carrier did not submit a response for consideration in this review.

By a preponderance of the evidence, DWC finds the change in effective dates for the work restrictions is a substantial change for which the provider may submit a work status report.

The insurance carrier's denial reasons are therefore unsupported. The service will thus be reviewed for payment.

Procedure code 99080-73 is a division specific code for a work status report with reimbursement subject to 28 TAC §129.5(i), which requires that reimbursement shall be $15. Payment of this amount is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of the division is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above, the requestor has established that additional payment is due. The amount ordered is $15.00.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable), based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $15.00, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	October 11, 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 TAC §133.307.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). DWC must receive the request within twenty days of your receipt of this decision.

You may fax, mail or personally deliver the request to either the field office handling the claim or to DWC at the contact information on the form. You must send a copy to all other parties in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** along with any other information required by 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.