TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Dismissal

General Information

Requestor Name
Dr. Kyle E. Jones

Respondent Name
Texas Mutual Insurance Co.

MFDR Tracking Number
M4-22-0530-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
November 15, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 25, 2021	CPT Code 99080-73	$15.00	$15.00
	Total	$15.00	$15.00

Requestor's Position

"A reconsideration letter was sent on 10/13/21 saying that there were indeed changes and requesting payment."

Amount in Dispute: $15.00

Respondent's Position

The Austin carrier representative for Texas Mutual Insurance Co is Texas Mutual Insurance Co. Texas Mutual Insurance Co received a copy of this medical fee dispute on November 23, 2021. 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).

Findings and Decision

Authority

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

Statutes and Rules

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.239 sets out medical fee guidelines for workers' compensation specific services.
3. 28 TAC §129.5 sets out the procedure for reporting and billing work status reports.

Denial Reasons

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

- CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.
- CAC-150-Payer deems the information submitted does not support this level of service.
- 248-DWC-73 in excess of filing requirements; no change in work status and/or restrictions; reimbursement denied per rule 129.5.
- DC4-No additional reimbursement allowed after reconsideration.
- CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is Texas Mutual Insurance Company's denial based on reason code "248" supported?

2. Is Dr. Kyle Jones entitled to reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $15.00 for CPT code 99080-73 rendered on August 25, 2021.

   According to the explanation of benefits, the carrier denied payment for the disputed work status report based upon "248-DWC-73 in excess of filing requirements; no change in work status and/or restrictions; reimbursement denied per rule 129.5."

The respondent did not submit any documentation to support the denial based upon reason code "248"; therefore, reimbursement is recommended.

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

   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."

   28 TAC §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."

   A review of the submitted documentations finds the requestor submitted a copy of the DWC-73 report to support billing. As a result, reimbursement of $15.00 is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement of $15.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Texas Mutual Insurance Co. must remit to Dr. Kyle Jones $15.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	03/01/2022 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.