



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

PEAK INTEGRATED HEALTHCARE

Respondent Name

INDEMNITY INSURANCE COMPANY

MFDR Tracking Number

M4-22-1310-01

Carrier's Austin Representative

Box Number 15

DWC Date Received

March 1, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 5, 2021 through September 9, 2021	99213, 99080-73 and 99361-W1 x 2	\$404.14	\$15.00
Total		\$404.14	\$15.00

Requestor's Supplemental Position

"We have not been paid on the 8/24/2021 99080 73 - amount \$15.00. All others have been paid."

Amount in Dispute: \$404.14

Respondent's Position

"Upon receipt of the MDR requested, the bill was sent for reconsideration. A payment of \$389.14 was issued on 3-16-22. Attached are copies of the EOR and the payment screens for the bill and interest payments issued."

Response Submitted by: ESIS

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 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the fee guideline for professional medical services.
3. 28 TAC §134.239 sets out the requirements for billing for a work status report.
4. 28 TAC §129.5 sets out the requirements for work status reports.

Denial Reasons

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

- Note – This procedure is allowed once every two calendar weeks.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Does the requestor continue to seek reimbursement for all of the disputed services?
2. Is the Insurance Carrier's denial reason supported for CPT Code 99080-73?
3. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Codes 99361-W1 rendered on August 5, 2021 and September 9, 2021 and CPT Codes 99213 and 99080-73 rendered on August 24, 2021.

The insurance carrier issued payment for CPT Codes 99361-W1 rendered on August 5, 2021 and September 9, 2021 and CPT Codes 99213 rendered on August 24, 2021.

The requestor states, "We have not been paid on the 8/24/2021 99080 73 - amount \$15.00. All others have been paid."

The requestor, therefore, seeks reimbursement for CPT Code 99080-73 rendered on August 24, 2021. As a result, CPT Code 99080-73 is reviewed pursuant to the applicable rules and guidelines.

2. The respondent denied reimbursement for CPT code 99080-73 rendered on August 24, 2021 with the denial reason codes indicated above.

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 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."

The DWC finds that the requestor's documentation supports the billing of CPT Code 99080-73. As a result, the insurance carrier's denial reason is not supported, and the requestor is entitled to reimbursement.

3. 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 completed the return-to-work report in accordance with the applicable rules; therefore, 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. The DWC finds the requester has established that reimbursement of \$15.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor \$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

May 24, 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 electrónico CompConnection@tdi.texas.gov.