

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

KYLE E JONES

Respondent Name

LIBERTY INSURANCE CORP

MFDR Tracking Number

M4-22-2294-01

Carrier's Austin Representative

Box Number 01

DWC Date Received

June 21, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 14, 2022	Code 99080-73	\$15.00	\$0.00

Requestor's Position

ON 4/14/22, [injured employee] had a follow-up visit in our office. A new DWC-73 form was filled out changing his restrictions from the previous report on 04/07/22 in the following way: ... The EOB received from this visit denied payment of the DWC-73 stating, 'Billing for report and/or record review exceeds reasonableness.' A reconsideration letter was sent on 05/17/22 saying that there were indeed changes and requesting payment. The subsequent EOB received denied payment again – 'Original payment decision is being maintained...'

Amount in Dispute: \$15.00

Respondent's Position

This bill for DOS 04/14/2022 has been reviewed and the denial is correct per Rule 129.5(3): on the schedule requested by insurance carrier, its agent, or the employer requesting the report through its insurance carrier, which shall not exceed one report every two weeks and which shall be based upon the doctor's, delegated physician assistant's, or delegated advanced practice registered nurse's scheduled appointments with the injured employee.

Attached is EOB from DOS 4/7/2022 showing payment for 99080-73 was issued to Kyle E Jones, MD TX & OK occupational Medicine Services.

Response Submitted by: Liberty Mutual

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 §134.29 sets out the fee guidelines for work status report billing.
3. 28 TAC §129.5 sets out the fee guidelines for work status reports.

Denial Reasons

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

- 190 – Billing for report and/or record review exceeds reasonableness
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Is Requestor entitled to additional reimbursement for CPT Code 99080-73?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of \$15.00 for CPT Code 99080-73 rendered on April 14, 2022.
 - 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 §134.29 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 (j) states " Notwithstanding any other provision of this title, a doctor,

delegated physician assistant, or delegated advanced practice registered nurse may bill for, and an insurance 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 insurance carrier, its agent, or the employer through its insurance carrier asks for an extra copy. The amount of reimbursement shall be \$15. A doctor, delegated physician assistant, or delegated advanced practice registered nurse 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, delegated physician assistants, or delegated advanced practice registered nurses are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors, delegated physician assistants, or delegated advanced practice registered nurses 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, delegated physician assistant, or delegated advanced practice registered nurse is billing for a report required under subsections (e)(1), (e)(2), and (g) of this section;

Review of the EOB submitted by the insurance carrier supports that a payment in the amount of \$15.00 was issued to the requestor. As a result, additional reimbursement cannot be 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 requestor has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature



Signature



Medical Fee Dispute Resolution
Officer

July 26, 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.