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

General Information

Requestor Name
KYLE ELLIOTT JONES, M.D.

Respondent Name
LIBERTY INSURANCE CORP.

MFDR Tracking Number
M4-22-2317-01

Carrier's Austin Representative
Box Number 01

DWC Date Received
June 24, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 19, 2022	99080-73	$15.00	$15.00
	Total	$15.00	$15.00

Requestor's Position

"CPT Code 99080-73 is for a Work Status Report (TWCC 73). Texas Division of Insurance rule 129.4 (i) - work status report: 'a doctor may bill for, and a carrier shall reimburse. . . the amount of reimbursement shall be $15.' This charge was denied for the following reason: 'Billing for report and/or record review exceeds reasonableness.' The restrictions were changed. This change was significant and warranted a new work status report."

Amount in Dispute: $15.00

Respondent's Position

"This bill for DOS 04/19/2022 has been reviewed and the denial is correct per Rule 129.5 €(3)[sic]: on the schedule requested by the 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 shill I be based upon the doctor's, delegated physician assistants, or delegated advanced practice registered nurse's scheduled appointments with the injured employee. Attached is EOB from DOS 4/07/2022 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 TAC §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 reduced or 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 the Insurance Carrier's denial reason supported?
2. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 99080-73 rendered on April 19, 2022.

   The insurance carrier denied the disputed service with denial reduction codes indicated above.

   CPT code 99080-73 is described as "Work Status Report."

   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 (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."

   28 TAC §129.5 (e)(3) states, "The doctor, delegated physician assistant, or delegated advanced practice registered nurse shall file the Work Status Report: (3) on the schedule requested by the 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 assistants, or delegated advanced practice registered nurse's scheduled appointments with the injured employee."

   A review of the submitted documentations finds that the requestor documented a change in the injured employees' condition, and therefore met the requirements of 28 TAC §129.5 (d)(1).

The requestor states, "On 04/19/2… had a follow-up visit in our office. A new DWC-73 form was filled out changing his restrictions from the previous report on 04/14/22 in the following way: -Motion Restrictions: Overhead reaching 2 hrs max, changed to no restriction -Posture Restrictions: Twisting – 2 hrs max, changed to 4 hrs max/day Bending – 2 hrs max, changed to no restriction."

The DWC finds that the insurance carrier's denial reasons are not supported. As a result, reimbursement of $15.00 is recommended for this report.

2. The DWC finds that the requestor is entitled to reimbursement in the amount of $15.00 for CPT Code 99080-73 rendered on April 19, 2022.

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 is 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

		November 3, 2022
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 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.