TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Robert B Zicterman

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-23-1798-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
March 23, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 30, 2023	99214	$196.43	$0.00
January 30, 2023	99080-73	$15.00	$0.00
	Total	$231.43	$0.00

Requestor's Position

No position statement was submitted by the requestor with the request for MFDR.

Amount in Dispute: $231.43

Respondent's Position

"The documentation submitted by the provider did not include a position statement for the disputed issue(s) as required by Rule 133.307(N). ...Our position is that no payment is due."

Response submitted by: Texas 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 guidelines for medical fee dispute resolution.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §129.5 details the requirements of work status reports.

Denial Reasons

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

- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
- P12 – Workers' Compensation jurisdictional fee schedule adjustment
- 150 – Payer deems the information submitted does not support this level of service
- 248 – DWC-73 in excess of the filing requirements; No change in work status and/or restrictions; Reimbursement denied per Rule
- 890 – Denied per AMA CPT code description for level of service and/or nature of presenting problems

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. The requestor is seeking reimbursement of $231.43 for Codes 99214 – "Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making" and 99080-73 – "Work Status Report."

   The insurance carrier denied the disputed service based on lack of information, documentation does not support and no change in work status and/or restrictions.

   Review of the submitted medical record indicates medical decision making was limited. The insurance carrier's denial for code 99214 is supported.

   DWC Rule TAC §129.5 (e) states, "The doctor, delegated physician assistant, or delegated advanced practice registered nurse shall file the Work Status Report:

   (1) after the initial examination of the injured employee, regardless of the injured

employee's work status;

(2) when the injured employee experiences a change in work status or a substantial change in activity restrictions; and

(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 assistant's, or delegated advanced practice registered nurse's scheduled appointments with the injured employee.

Review of the submitted DWC073 did not indicate a change in work status or activity restrictions or requested by the insurance carrier. The insurance carrier's denial is supported. No additional reimbursement 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 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

		May 2, 2023
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.