



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

JOSEPH O. MUSCAT, IV, MD

Respondent Name

UNITED AIRLINES INC

MFDR Tracking Number

M4-17-3759-01

Carrier's Austin Representative

Box Number 48

MFDR Date Received

AUGUST 21, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We received an Explanation of Benefits denying code 99080/73 stating that documentation was not attached to support the charge. Therefore we have attached the DWC 73 to support the charges we billed and are asking that you send the claim back for reprocessing and issue the provider the payment we are due for this code."

Amount in Dispute: \$15.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider has submitted a CMS-1500 with progress reports. The provider did not submit the TWC form as required for payment. Per Texas Workers Compensation, Clinical or progress notes do not constitute a narrative report. Narrative reports are billed with procedure code 99080."

Response Submitted By: Gallagher Basset Services, Inc.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: February 15, 2017, CPT Code 99080-73 Work Status Report, \$15.00, \$15.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 1. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
2. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
3. 28 Texas Administrative Code §134.239, effective July 7, 2016 refers to §129.5 for billing of work status reports.

4. 28 Texas Administrative Code §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
5. The services in dispute were reduced / denied by the respondent with the following reason codes:
  - 892-Billed date exceeds 95 days from date of service.
  - 18-Duplicate claim/service
  - B12-Services not documented in patients' medical records.
  - P12-Workers' compensation jurisdictional fee schedule adjustment.
  - 45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

### Issues

1. Did the requestor support position that the disputed bills were submitted timely?
2. Does the documentation support billing DWC-73?
3. What is the applicable fee guideline for DWC-73?
4. Is the requestor due reimbursement for DWC-73?

### Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the services in dispute based upon reason code "892-Billed date exceeds 95 days from date of service."

Texas Labor Code §408.027(a) states, "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

28 Texas Administrative Code §102.4(h), states, "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." A review of the submitted documentation does not contain any evidence such as a fax, personal delivery, electronic transmission, or certified green cards to support the bill was sent to the respondent within the 95 day deadline.

A review of the submitted documentation finds an explanation of benefits from respondent dated March 27, 2017 for the disputed service, this date is within the 95 day timeframe; therefore, the respondent did not support denial based upon reason code "892."

2. The respondent also denied reimbursement for the work status report, CPT code 99080-73, based upon "B12-Services not documented in patients' medical records."

A review of the submitted medical records finds a copy of the DWC-73 form; therefore, the respondent's denial based upon reason code "892" is not supported.

3. The fee guideline for work status reports is found in 28 Texas Administrative Code §134.239.

28 Texas Administrative Code §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."

4. 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 Texas Administrative Code §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 respondent submitted a copy of the work status report that dated February 15, 2017 that supports billing per 28 Texas Administrative Code §129.5; therefore, reimbursement of \$15.00 is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$15.00.

**ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$15.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
Date

9/20/2017

**YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**