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

General Information

Requestor Name
Kyle Jones MD

Respondent Name
American Zurich Insurance Company

MFDR Tracking Number
M4-25-0503-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
October 29, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 18, 2024	99080-73	$15.00	$15.00

Requestor's Position

"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 09/06/24, saying that there was a change in restrictions and requesting payment. We never received an EOB or payment, so we called. Ref # ..., 'Reconsideration processed, and original denial upheld. No additional payment will be made.'"

Amount in Dispute: $15.00

Respondents' Position

The Austin carrier representative for American Zurich Insurance Company is Flahive Ogden & Latson. Flahive Ogden & Latson was notified of this medical fee dispute on November 5, 2024. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.305 sets out the procedures for resolving medical disputes.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 TAC §129.5 sets out the fee guidelines for the DWC73 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.
- P12 - Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Are the insurance carrier's denial reasons supported?
2. Is the requestor entitled to reimbursement for Work Status Report 99080-73?

Findings

1. The requestor seeks reimbursement for a work status report, billed under CPT code 99080-73 and rendered on June 18, 2024. The insurance carrier denied the work status report with denial reason codes "190 - Billing for report and/or record review exceeds reasonableness."

   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 documentation finds that the requestor met the documentation requirements outlined in 28 TAC §129.5. Specifically, the requestor supported that the injured employee experienced a change in activity restrictions, therefore supporting the filing of a Work Status Report rendered on June 18, 2024.

2. The requester seeks reimbursement in the amount of $15.00 for code 99080-73, Work Status Report, rendered on June 18, 2024.

28 TAC §129.5(i)(1) which applies to the reimbursement of Work Status Reports 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… 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."

Because the insurance carrier's denial reason of the disputed service is not supported, the division finds that the requestor is entitled to reimbursement in the amount of $15.00, for the Work Status Report, CPT 99080-73 rendered on June 18, 2024.

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 division finds the requester is entitled to reimbursement in the amount of $15.00 for the service in dispute.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed service. It is ordered that the respondent must remit payment of $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	February 19, 2025 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, 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.