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
Kyle Elliott Jones, M.D.

Respondent Name
Sentry Insurance Company

MFDR Tracking Number
M4-25-0599-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
November 9, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 6, 2024	99080-73	$15.00	$15.00

Requestor's Position

"[Patient name] was seen for a follow-up visit on 9/6/24. The following restrictions were added to his work status … These changes warranted a new work status report. The carrier denied payment of this report, stating 'The frequency of this procedure codes exceeds the limitations specified in the fee schedule.' A reconsideration was sent on 9/26/24, stating why a new work status report was necessary. A denial EOB was received on 10/7 stating the same reason. We are requesting the remaining $15 and believe we have submitted all appropriate documentation for the amount charged."
Amount in Dispute: $15.00

Respondents' Position

"Per Texas Administrative Code Work Status Reports 129.5… the provider shall file the work status report not to exceed one report every 2 weeks. As we stated on the reconsideration EOB that was provided to the providers office, the same billing provider had billed for a work status report for date of service 8/30/2024 and was reimbursed. Therefore, reimbursement for date of service 9/6/2024 is not warranted as it is within the 2-week timeframe."
Response Submitted by: Sentry Insurance

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:

- 350 - Bill has been identified as a request for reconsideration or appeal.
- H46 - The frequency of this procedure codes exceeds the limitations specified in the fee schedule.
- P12 - Workers' compensation jurisdictional fee schedule adjustment.
- W3 - In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 151 - Payment adjusted because the payer deems the information submitted does not support this many/ frequency of services

Issues

1. Are the insurance carrier's reimbursement 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 September 6, 2024. The insurance carrier denied the work status report with denial reason codes H46 and 151, described above.

   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 copy of an EOB was provided by the insurance company to support payment for a DWC-73 that was completed on August 30, 2024. The proof, however, did not support that the injured employee did not experience a change in activity or restrictions. The division concludes that the rationale for denial, provided by the insurance carrier, is not supported.

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 September 6, 2024.

2. The requestor seeks reimbursement in the amount of $15.00 for code 99080-73, Work Status Report, rendered on September 6, 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 Work Status Report 99080-73 rendered on September 6, 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 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 services. 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	December 2, 2024 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.