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**
Ashley Ferguson, FNP-C

**Respondent Name**
Zurich American Insurance Co

**MFDR Tracking Number**
M4-25-1032-01

**Carrier's Austin Representative**
Box Number 19

**DWC Date Received**
January 14, 2025

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| June 5, 2024 | 99080-73 | $15.00 | $0.00 |

## Requestor's Position

"We are filing a MDR due to the carrier issuing the incorrect reimbursement for CPT code 99080. It was denied payment because the carrier states that the provider cannot bill for a work status report more than once every two weeks. Unfortunately, this was an incorrect denial by the carrier because the carrier has misinterpreted the DWC rule."

**Amount in Dispute:** $15.00

## Respondents' Position

The Austin carrier representative for Zurich American Insurance Co is Flahive Ogden & Latson. Flahive Ogden & Latson was notified of this medical fee dispute on January 23, 2025. 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.
- TXP12, P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – Bill is a reconsideration or appeal.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.

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 requester seeks reimbursement for a work status report, billed under CPT code 99080-73 and rendered on June 5, 2024. The insurance carrier denied the work status report with denial reason code "190 – Billing for report and/or record review exceeds reasonableness."

   DWC Rule §129.5 (e)(1)(2)(3) 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 assistants, or delegated advanced practice registered nurse's scheduled appointments with the injured employee.

A review of the DWC-73 report finds insufficient documentation to support that the injured employee experienced a change in activity or restrictions or, documentation of a request by the insurance carrier, its agent, or the employer. The division concludes that the rationale for denial, provided by the insurance carrier, is supported.

2. The requestor seeks reimbursement in the amount of $15.00 for code 99080-73, Work Status Report, rendered on June 5, 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 supported, the division finds that the requestor is not entitled to reimbursement in the amount of $15.00, for Work Status Report 99080-73 rendered on June 5, 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.

DWC finds the requestor has not established that reimbursement is due.

## Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed service.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | April 11, 2025<br>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.