



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

JOSE A. FIGUEROA, DC

Respondent Name

ACE AMERICAN INSURANCE CO

MFDR Tracking Number

M4-16-0051-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

SEPTEMBER 8, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "E/M codes do not require prior authorization and services rendered were reasonable and necessary."

Amount in Dispute: \$345.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier obtained a peer review that indicated continued treatment was not supported by ODG. Treatment that is outside ODG requires preauthorization. The provider did not obtain preauthorization for the dates of service 11/17/14 and 11/20/14. Therefore, it is the Carrier's position that the provider is not entitled to reimbursement."

Response Submitted By: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 17, 2014	CPT Code 99213 Office Visit	\$165.10	\$114.48
	CPT Code 99080-73 Work Status Report	\$15.00	\$0.00
November 20, 2014	CPT Code 99213 Office Visit	\$165.10	\$114.48
TOTAL		\$345.20	\$228.96

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. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets out medical fee guidelines for workers' compensation specific services.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
4. 28 Texas Administrative Code §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
5. 28 Texas Administrative Code §134.600 requires preauthorization for specific treatments and services.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - TX02-No proof of pre-auth.
 - 197-Precertification/authorization/notification absent.
 - 18-Duplicate claim/service.
 - 148-This procedure on this date was previously reviewed.

Issues

1. Does a preauthorization issue exist?
2. Does the documentation support billing code 99213? Is the requestor entitled to reimbursement?
3. Does the documentation support billing code 99080-73? Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the office visit based upon a lack of preauthorization.

A review of 28 Texas Administrative Code §134.600(p) finds that office visits are not listed as a service that requires preauthorization; therefore, the respondent's denial is not supported.

2. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

CPT code 99213 is defined as "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family."

The requestor submitted copies of the medical reports to support billed service; therefore, reimbursement is recommended.

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this

annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007.”

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2014 DWC conversion factor for this service is 55.75.

The Medicare Conversion Factor is 35.8228

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77504, which is located in Pasadena, TX; therefore, the Medicare participating amount is based on locality “Houston, Texas”.

The Medicare participating amount for code 99213 is \$73.56.

Using the above formula, the MAR is \$114.48. The requestor billed for two dates of service which equals $\$114.48 \times 2 = \228.96 . This amount is recommended for reimbursement.

3. 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 §134.204 (l) states “The following shall apply to Work Status Reports. When billing for a Work Status Report that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section, refer to §129.5 of this title (relating to Work Status Reports).”

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.”

28 Texas Administrative Code §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 work status report showed no change in claimant’s work status to support billing report in accordance with 28 Texas Administrative Code §129.5 (d)(2); therefore, reimbursement cannot be 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 \$228.96.

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 \$228.96 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

10/23/2015

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.