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
ORTHO TEXAS PHYSICIANS & SURGEONS

MFDR Tracking Number
M4-17-3011-01

MFDR Date Received
June 13, 2017

Respondent Name
GREAT AMERICAN ALLIANCE INSURANCE

Carrier's Austin Representative
Box Number 19

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Attached is everything needed for consideration of this claim. Please process for payment."

Amount in Dispute: $190.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "There are causal relation issues. Treatment for [diagnosis] is not related to the claim injury."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
January 19, 2017	99213 and 99080-73	$190.00	$128.52

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 §129.5 sets out the procedure work status reports.
3. 28 Texas Administrative Code §137.100 sets out the Treatment Guidelines.
4. 28 Texas Administrative Code §133.240 sets out the Medical Payments and Denials.
5. 28 Texas Administrative Code §19.2003 sets out the definitions for Utilization Reviews for Health Care Provided under Workers' Compensation Insurance Coverage.
6. 28 Texas Administrative Code §134.203 sets out the sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - 270 – No allowance has been recommended for this procedure/service/supply please see special *note* below
   - Note: If allowance is recommended, payment to follow under separate cover
   - 270 – Denied per peer review treatment no longer medically necessary per ODG's for the accepted work injury

Issues

1. Does the respondent's position statement address only the denial reasons presented to the requestor prior to the date the request for MFDR was filed?
2. Are the insurance carrier's reasons for denial of payment for CPT Codes 99213 and 99080-73 supported?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed CPT Codes 99213 and 99080-73 rendered on January 19, 2017. The insurance carrier in the position summary states in pertinent part, "There are causal relation issues. Treatment for [diagnosis] is not related to the claim injury."

   28 Texas Administrative Code §133.307(d)(2)(F) states "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

   The respondent submitted a position summary containing new denial reasons. The additional denial reasons identified on the position summary, "There are causal relation issues. Treatment for [diagnosis] is not related to the claim injury," are not denial reasons raised during the medical bill review process, as they are not indicated on the Explanation of Benefits (EOBs) presented with the DWC060 request. The Division finds that the respondent submitted insufficient information to MFDR to support that the submitted denial reasons raised in their position summary were presented to the requestor, or that the requestor had otherwise been informed of these new denial reasons or defenses, prior to the date that the request for medical fee dispute resolution was filed with the Division; therefore, the Division concludes that the respondent has waived the right to raise such additional denial reasons or defenses. Any newly raised denial reasons or defenses shall not be considered in this review.

2. The requestor seeks reimbursement for CPT Codes 99213 and 99080-73 rendered on January 19, 2017. The insurance carrier denied the disputed services with denial reason codes "16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication;" "270 – No allowance has been recommended for this procedure/service/supply please see special *note* below" and "270 – Denied per peer review treatment no longer medically necessary per ODG's for the accepted work injury."

   28 Texas Administrative Code §137.100 (e) states,

   > An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017.

   Retrospective utilization review is defined in 28 Texas Administrative Code §19.2003 (b) (31) as,

   > A form of utilization review for health care services that have been provided to an injured employee. Retrospective utilization review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted.

   In addition, 28 Texas Administrative Code §133.240 (q) states, in relevant part,

   > When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title ... Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title …, including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor ...

   Submitted documentation does not support that the insurance carrier followed the appropriate procedures for a retrospective review denial of the disputed services outlined in §19.2003 (b) (31) or §133.240 (q). The insurance carrier's denial for this reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

The Division finds that CPT Code 99213 is subject to reimbursement pursuant to 28 Texas Administrative Code §134.203 (c). 28 Texas Administrative Code §134.203 (c) states in pertinent part, "(c) 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... 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..."

Procedure code 99213, January 19, 2017, has a Work RVU of 0.97 multiplied by the Work GPCI of 1 is 0.97. The practice expense RVU of 1.02 multiplied by the PE GPCI of 0.929 is 0.94758. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.809 is 0.05663. The sum is 1.97421 multiplied by the DWC conversion factor of $57.50 for a MAR of $113.52. Therefore, this amount is recommended.

Procedure Code 99080 is subject to reimbursement pursuant to 28 Texas Administrative Code §129.5 states in pertinent part, "(i) 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."

Review of the submitted documentation supports the billing of CPT Code 99080-73, as a result, the requestor is entitled to reimbursement in the amount of $15.00.

3. Review of the submitted documentation finds that the requestor is entitled to a total reimbursement in the amount of $128.52. As a result, this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $128.52.

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 $128.52 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	April 25, 2019 Date

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.