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
VED V. AGGARWAL, MD

Respondent Name
TRUMBULL INSURANCE CO

MFDR Tracking Number
M4-18-1905-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
FEBRUARY 6, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This was the first patients Visit to our Physicians office with Services being rendered by Kent Mitchell MD. According to the Adjuster…she stated the claim was still under investigation and therefore that is why the claim more than likely denied.

Amount in Dispute: $263.75

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our investigation found the following: Services not authorized. PLN 11 filed on disability 04/21/17."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 22, 2017	CPT Code 99204 Office Visit	$263.75	$263.00
	HCPCS Code G8730 Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications	$0.00	$0.00
	HCPCS Code G8427 Pain assessment documented as positive using a standardized tool and a follow-up plan is documented	$0.00	$0.00
TOTAL		$263.75	$263.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 §141.1 sets out the procedures for Requesting and Setting a Benefit Review Conference.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197-Payment denied/reduced for absence of precertification/authorization.
   - APPR-Reimbursement is being withheld as the treating doctor and/or services rendered were not approved based upon handler review. If you require additional information regarding this bill decision, contact the claim handler.
   - W3-Additional payment made on appeal/reconsideration..

Issues

1. Did the respondent submit the response in accordance with 28 Texas Administrative Code §133.307?
2. Does a preauthorization issue exist in this dispute?
3. Was the claimant referred by the treating doctor to requestor for evaluation?
4. Is the requestor entitled to reimbursement?

Findings

1. The respondent states in the position summary that "Our investigation found the following: Services not authorized. PLN 11 filed on disability 04/21/17."

   The respondent submitted a copy of the PLN11 –Notice of Disputed Issue(s) and refusal to Pay Benefits disputing the extent of injury.

   On [redacted] the claimant sustained a low back injury.

   28 Texas Administrative Code §133.307(d)(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. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section."

   The Division finds that the submitted explanation of benefits does not list any denial reasons to support the extent of injury issues raised in the position summary; therefore, the response was not submitted in accordance with 28 Texas Administrative Code §133.307.

2. According to the explanation of benefits, the respondent denied reimbursement for CPT code 99204 based upon "197-Payment denied/reduced for absence of precertification/authorization."

   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 99204 is described as "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or 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 moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family."

28 Texas Administrative Code §134.600(p)(1-14) outlines the non-emergency services that require preauthorization. A review of the list does not include office visits; therefore, a preauthorization issue does not exist.

3. According to the explanation of benefits, the respondent also denied reimbursement for CPT code 99204 based upon "APPR-Reimbursement is being withheld as the treating doctor and/or services rendered were not approved based upon handler review. If you require additional information regarding this bill decision, contact the claim handler."
   The requestor noted that the claimant was referred to them by Dr. Mario A. Leza for evaluation of claimant's low back pain. The respondent did not dispute that Dr. Leza was claimant's treating doctor. The division finds the respondent's denial is not supported.
4. The applicable fee guideline for the remaining disputed services is found at 28 Texas Administrative Code §134.203.

   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 2017 DWC conversion factor for this service is 57.5

   The 2017 Medicare Conversion Factor is 35.8887

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 76104, which is located in Fort Worth, Texas; therefore, the Medicare participating amount is based on locality "Fort Worth, Texas".

   The Medicare participating amount for code 99204 at this location is $164.15.

   Using the above formula the division finds the MAR is $263.00; this amount is recommended for reimbursement.

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 $263.00.

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 $263.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		03/5/2018
Signature	Medical Fee Dispute Resolution Officer	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, 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 MFDR 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.