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
ELITE HEALTHCARE GARLAND

Respondent Name
INDEMNITY INSURANCE COMPANY OF NORTH AMERICA

MFDR Tracking Number
M4-19-0636-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
October 4, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per ODG guidelines, office visits are recommended to be medically necessary."

Amount in Dispute: $135.69

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "DWC Rule 134.600(p)(12) requires all treatment that exceed or are not addressed by the commissioner's adopted treatment guidelines require preauthorization. The treatment in dispute is an office which exceed the expected number of office visits for the Claimant's condition in the Official Disability Guidelines."

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
July 31, 2018	Professional Medical Services	$135.69	$135.68

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 §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §134.600 sets out rules regarding preauthorization of health care.
4. 28 Texas Administrative Code §137.100 sets out the division's treatment guidelines.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION.
   - 5264 – Payment is denied–service not authorized.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

- 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.

Issues

1. Was preauthorization required?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes:
   - 197 – PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION.
   - 5264 – Payment is denied–service not authorized.

   The requestor states, "Per ODG guidelines, office visits are recommended to be medically necessary."

   The respondent states, "DWC Rule 134.600(p)(12) requires all treatment that exceed or are not addressed by the commissioner's adopted treatment guidelines require preauthorization."

   Rule §134.600(c)(1) requires the insurance carrier to be liable for all reasonable and necessary medical costs relating to the health care listed in subsection (p) only when the following situations occur:

   (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);

   (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care;

   The disputed services involve evaluation and management code 99213 and a work status report, code 99080-73.

   Rule § 134.600 (p) does not list office visits or evaluation and management services as requiring preauthorization.

   However, the respondent asserts the services still require preauthorization due to Rule §134.600(p)(12), which requires preauthorization for "treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols…"

   The commissioner's treatment guidelines are adopted by reference in Rule §137.100(a), which requires health care providers to treat "in accordance with the current edition of the Official Disability Guidelines - Treatment in Workers' Comp, excluding the return to work pathways, (ODG), published by Work Loss Data Institute…"

   Review of division treatment guidelines current to the date of service finds that office visits are "Recommended as determined to be medically necessary." The guidelines state further that:

   > Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. … As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established.

   Because Rule §134.600(p) does not require authorization for office visits or evaluation and management services and because the division treatment guidelines recommend evaluation and management office visits and further do not set any numerical limits on such visits, the division concludes the respondent's position is without merit.

   The insurance carrier's denial reasons are not supported. Consequently, the disputed services will be reviewed for reimbursement in accordance with division rules and fee guidelines.

2. This dispute regards medical services with reimbursement subject to the *Medical Fee Guideline for Professional Services*, 28 Texas Administrative Code §134.203, requiring the maximum allowable reimbursement (MAR) be determined by Medicare payment policies modified by DWC rules. The MAR is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the DWC annual conversion factor. Reimbursement is calculated as follows:
   - Procedure code 99213, July 31, 2018, has a Work RVU of 0.97 multiplied by the Work GPCI of 1.012 is 0.98164. The practice expense RVU of 1.02 multiplied by the PE GPCI of 1.014 is 1.03428. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.768 is 0.05376. The sum is 2.06968 multiplied by the DWC conversion factor of $58.31 for a MAR of $120.68.
   - Procedure code 99080-73 is a division specific code for a work status report with reimbursement subject to 28 Texas Administrative Code §129.5(i), which requires that "reimbursement shall be $15."

   The total allowable reimbursement for the disputed services is $135.68. The insurance carrier paid $0.00. The amount due is $135.68. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division emphasizes that the findings in this decision are based on the evidence presented by the requestor and respondent available at the time of review. Even though not all the evidence was discussed, it was considered.

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 $135.68.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $135.68, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	January 18, 2019
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 Rule §133.307.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.