



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

DR. MONZER H. YAZJI

Respondent Name

PROPERTY & CASUALTY INS CO OF HARTFORD

MFDR Tracking Number

M4-19-2025-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

DECEMBER 7, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Attached to this request are the CMS1500, EOB, and the medical documentation that supports the service provided to the patient."

Amount in Dispute: \$170.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As reflected in the attached EOB, the Carrier properly reimbursed Dr. Yazji in accordance with the Division Fee Guidelines. Accordingly, Carrier requests that the Division dismiss this medical dispute."

Response Submitted By: Burns Anderson Jury & Brenner, LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 4, 2018	CPT Code 99213 Office Visit	\$150.00	\$0.00
	CPT Code 99080-73 Work Status Report	\$20.00	\$0.00
TOTAL		\$170.00	\$0.00

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 §134.239, effective July 7, 2016, 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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 226-Information requested from the billing/rendering provider was not provided or not provided timely or was insufficient/incomplete.
 - 16-Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
 - 5205-Cannot review bill without medical notes for date(s) of service. Please submit medical notes with the bill to expedite processing.
 - 5083-OP report/medical records are required for review. Please re-submit bill with proper information for further processing.
 - 18-Exact duplicate claim/service.
 - 247-A payment or denial has already been recommended for this service.
 - W3-Additional payment made on appeal/reconsideration.
 - P12-Workers' compensation jurisdictional fee schedule adjustment.
 - 948-Re-reviewed at providers request with additional information and documentation additional payment suggested.

Issues

1. What is the applicable fee guideline?
2. Does the documentation support billing CPT code 99213? Is the requestor due reimbursement?
3. Does the documentation support billing CPT code 99080-73? Is the requestor due reimbursement?

Findings

1. The fee guidelines for disputed services are found in 28 Texas Administrative Code §134.203.
2. The insurance carrier denied reimbursement for the office visit, CPT code 99213, based upon reason code "226-Information requested from the billing/rendering provider was not provided or not provided timely or was insufficient/incomplete," "16- Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate," "5205- Cannot review bill without medical notes for date(s) of service. Please submit medical notes with the bill to expedite processing," "5083-OP report/medical records are required for review. Please re-submit bill with proper information for further processing," "948-Re-reviewed at providers request with additional information and documentation additional payment suggested," and "P12-Workers' compensation jurisdictional fee schedule adjustment." The respondent states, "As reflected in the attached EOB, the Carrier properly reimbursed Dr. Yazji in accordance with the Division Fee Guidelines." The respondent attached an EOB that indicates payment of \$115.60 was made for CPT code 99213.

To determine if additional reimbursement is due the division refers to 28 Texas Administrative Code §134.203.

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 99214 is described 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."

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 2018 DWC conversion factor for this service is 58.31.

The Medicare Conversion Factor is 35.9996

Review of Box 32 on the CMS-1500 the services were rendered in Edinburg, Texas; therefore, the locality will be based on the rate for "Rest of Texas".

The Medicare participating amount for code 99213 in Rest of Texas is \$71.37.

Using the above formula, the MAR is \$115.60. The respondent paid \$115.60. The division finds the requestor was paid for the division fee guideline and additional reimbursement is not due.

3. The respondent initially denied reimbursement for CPT code 99080-73 based upon reason codes "5205- Cannot review bill without medical notes for date(s) of service. Please submit medical notes with the bill to expedite processing," and "226-Information requested from the billing/rendering provider was not provided or not provided timely or was insufficient/incomplete." Upon reconsideration, the respondent paid \$15.00 per the fee guideline.

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 §134.239 states, "When billing for a work status report that is not conducted as a part of the examinations outlined in §134.240 and §134.250 of this title, refer to §129.5 of this title."

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 submitted explanation of benefits finds the respondent paid \$15.00 in accordance with 28 Texas Administrative Code §129.5. As a result, additional reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

Date

01/11/2019

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.