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
ORTHOTEXAS PHYSICIANS & SURGEONS

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-19-2301-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
December 21, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Dr. Allmon is a different specialty with a different taxonomy code … therefore Dr. Allmon should be reimbursed for the new patient evaluation."

Amount in Dispute: $250.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office will maintain our denial of B16 – payment adjusted because 'New Patient' qualifications were not met as both physicians are of the same specialty."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
July 27, 2018	Professional Medical Services	$250.00	$0.00

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 §134.203 sets out the fee guideline for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 56 – SIGNIFICANT, SEPARATELY IDENTIFIABLE E/M SERVICE RENDERED.
   - 886 – THE PROCEDURE WAS INAPPROPRIATELY BILLED. THE PROVIDER HAS PREVIOUSLY BILLED FOR AN INITIAL/EVALUATION VISIT.
   - B16 – 'NEW PATIENT' QUALIFICATIONS WERE NOT MET.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

Issue

Are the insurance carrier's reasons for denial of payment supported?

Findings

This dispute regards "new patient" evaluation code 99203 billed by the provider for the same date that another doctor in the same practice also billed a "new patient" evaluation service.

The insurance carrier denied payment for the service with claim adjustment reason codes:

- 886 – THE PROCEDURE WAS INAPPROPRIATELY BILLED. THE PROVIDER HAS PREVIOUSLY BILLED FOR AN INITIAL/EVALUATION VISIT.
- B16 – 'NEW PATIENT' QUALIFICATIONS WERE NOT MET.

The respondent states, "'New Patient' qualifications were not met as both physicians are of the same specialty."

In support, the respondent provided print-outs of Health Care Provider Detail records from TXCOMP, a database maintained by the Texas Department of Insurance, listing both providers with the specialty of "Surgery, Orthopedic."

On the other hand, the requestor contends, "Dr. Allmon is a different specialty with a different taxonomy code … therefore Dr. Allmon should be reimbursed for the new patient evaluation."

In support, the requestor provided print-outs from the CMS National Plan and Provider Enumeration System (NPPES) National Provider Identifier (NPI) records website showing the requesting doctor's specialty as "Orthopaedic Surgery Hand Surgery," whereas the other doctor's specialty is listed as "Orthopaedic Surgery Sports Medicine."

Based on the submitted information, both doctors share the same specialty — orthopedic surgery; although, the two doctors have different subspecialties — hand surgery and sports medicine.

Rule §134.203(b)(1) requires that for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply Medicare payment policies, including its coding, billing and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

Rule §134.203(a)(5) defines "Medicare payment policies" to 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.

Medicare Claims Processing Manual, Chapter 12 - Physicians/ Nonphysician Practitioners, §30.6.7 - Payment for Office or Other Outpatient Evaluation and Management (E/M) Visits (Codes 99201 - 99215), A. *Definition of New Patient for Selection of E/M Visit Code* states:

> Interpret the phrase "new patient" to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous 3 years.

Medicare Claims Processing Manual, Chapter 12, §30.6.7 B. *Office/Outpatient E/M Visits Provided on Same Day for Unrelated Problems* further requires that for all other E/M services, payers:

> may not pay two E/M office visits billed by a physician (or physician of the same specialty from the same group practice) for the same beneficiary on the same day unless the physician documents that the visits were for unrelated problems in the office … setting which could not be provided during the same encounter …

Review of the submitted information finds both physicians worked for the same group practice (OrthoTexas Physicians and Surgeons) and that both physicians shared the same specialty (orthopedic surgery). The submitted medical record failed to document that the two evaluations were for unrelated problems.

Accordingly, the division finds the requestor failed to meet the requirements of Medicare payment policies and division rules to support the use of "new patient" evaluation code 99203. Consequently, the insurance carrier's denial reason is supported. No additional payment can be 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 not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	January 11, 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.