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
SHERWIN WILLIAMS CO.

MFDR Tracking Number
M4-19-3323-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
February 28, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per adjuster … this case is closed & that is why this claim denied for no pre-cert. Per Labor Code 408.021(d) 'an insurance carrier's liability for medical benefits may NOT be limited or terminated by agreement or settlement'."

Amount in Dispute: $785.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "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
April 19, 2018 to January 29, 2019	Professional Medical Services	$785.00	$525.81

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION.
   - 5343 – Please note this is the Reconsideration for a prior review.
   - 5264 – Payment is denied–service not authorized.
   - 219 – Based on extent of injury.
   - 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. Are there any unresolved issues of extent of injury?
2. Did the provider fail to obtain preauthorization?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code:
   - 219 – Based on extent of injury.

   However, this denial reason was not maintained after reconsideration. Accordingly, the division concludes there are no outstanding issues regarding extent of injury. The disputed fee issues are therefore eligible for review in accordance with the Texas Labor Code and division rules.

2. 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.

   Rule §134.600(c)(1)(B) requires the insurance carrier be liable for all reasonable and necessary medical costs relating to the health care listed in subsection (p) or (q) 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) … approved prior to providing the health care;
   (C) concurrent utilization review of any health care listed in subsection (q) … approved prior to providing the health care; or
   (D) when ordered by the commissioner;

   The disputed evaluation services are not listed among the services requiring preauthorization in Rule §134.600(p); however, the insurance carrier contends the services still require preauthorization because they "exceed the expected number of office visits for the Claimant's condition in the Official Disability Guidelines."

   Rule §134.600(p)(12) states that non-emergency health care requiring preauthorization includes "treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols…"

   Review of the division treatment guidelines finds that office visits are "Recommended as determined to be medically necessary."

   The treatment guidelines further specify in regard to office visits and evaluation and management services:

   > The ODG Utilization Review Advisor (UR Advisor), designed to automate claims management decision-making, indicates the number of E&M office visits (codes 99201-99285) reflecting the typical number of E&M encounters for a diagnosis, but this is not intended to limit or cap the number of E&M encounters that are medically necessary for a particular patient. Office visits that exceed the number of office visits listed in the UR Advisor may serve as a "flag" to payers for possible evaluation; however, payers should not automatically deny payment for these if preauthorization has not been obtained. Note: The high-quality medical studies required for treatment guidelines such as ODG provides guidance about specific treatments and diagnostic procedures, **but not about the recommended number of E&M office visits.** Studies have and are being conducted as to the value of "virtual visits" compared with inpatient visits, however the value of patient/doctor interventions has not been questioned.

   Based on division treatment guidelines, the division concludes there is no numerical limit in the Official Disability Guidelines as to the number of recommended office visits. Accordingly, the medical provider has not exceeded the commissioner's adopted treatment guidelines or protocols. Consequently, Rule §134.600(c) does not require preauthorization for office visits or the disputed evaluation and management services.

   The insurance carrier's payment denial reasons are without merit. The disputed services will therefore be reviewed for reimbursement in accordance with division rules and fee guidelines.

3. 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, April 19, 2018, 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 0.938 is 0.95676. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.796 is 0.05572. The sum is 1.98248 multiplied by the DWC conversion factor of $58.31 for a MAR of $115.60.
   - Procedure code 99080-73, April 19, 2018, is a division specific code for a work status report with payment subject to 28 Texas Administrative Code §129.5(i), which requires that "reimbursement shall be $15."
   - Procedure code 99213, October 9, 2018, 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 0.938 is 0.95676. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.796 is 0.05572. The sum is 1.98248 multiplied by the DWC conversion factor of $58.31 for a MAR of $115.60.
   - Procedure code 99080-73, October 9, 2018, is a division specific code for a work status report with payment subject to 28 Texas Administrative Code §129.5(i), which requires that "reimbursement shall be $15."
   - Procedure code 99213, November 6, 2018, 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 0.938 is 0.95676. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.796 is 0.05572. The sum is 1.98248 multiplied by the DWC conversion factor of $58.31 for a MAR of $115.60.
   - Procedure code 99080-73, November 6, 2018, is a division specific code for a work status report with payment subject to 28 Texas Administrative Code §129.5(i), which requires that "reimbursement shall be $15."
   - Procedure code 99213, January 29, 2019, has a Work RVU of 0.97 multiplied by the Work GPCI of 1 is 0.97. The practice expense RVU of 1.05 multiplied by the PE GPCI of 0.938 is 0.9849. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.796 is 0.05572. The sum is 2.01062 multiplied by the DWC conversion factor of $59.19 for a MAR of $119.01.
   - Procedure code 99080, January 29, 2019, is a division specific code for a work status report with payment subject to 28 Texas Administrative Code §129.5(i), which requires that "reimbursement shall be $15."

   The total allowable reimbursement for the services in dispute is $525.81. The insurance carrier paid $0.00. The amount due is $525.81. 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 the findings in this decision are based on the available evidence presented by the requestor and respondent up to 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 $525.81.

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 $525.81, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	April 12, 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.