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
DAVID R. LONG, MD, PA

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-19-3738-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
APRIL 8, 2019

REQUESTOR'S POSITION SUMMARY

"The services provided on 05/07/2018 were denied as not covered due to follow up testing is not covered after initial testing is done for exposure. According to CDC recommendation are for testing baseline 6 weeks, 3 months and 6 months. Also SORM did not generate a PLN disputing the additional testing after the initial."

Amount in Dispute: $512.00

RESPONDENT'S POSITION SUMMARY

"the Office performed an in-depth review of the requestor's billing and determined that payment is not due for the services performed on 5/07/2018 and 8/13/2018…There is no evidence provided to the carrier that the injured employee sustained an injury as defined in Texas Labor Code §408.011(26); Therefore, the carrier reimbursed all initial testing that was performed on 2/08/2018. Furthermore, there is no language in Rule §122.3 that would support follow up testing and/or treatment where there is no evidence of an injury being sustained."

Response Submitted by: State Office of Risk Management (SORM)

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 7, 2018	CPT Code 86704	$50.00	$18.60
May 7, 2018	CPT Code 86708	$54.00	$19.11
May 7, 2018	CPT Code 86803	$70.00	$22.01
May 7, 2018	CPT Code 87340	$42.00	$15.93
May 7, 2018	CPT Code 86703	$55.00	$21.15
August 13, 2018	CPT Code 99213	$125.00	$115.60

August 13, 2018	CPT Code 99080-73	$15.00	$0.00
August 13, 2018	CPT Code 36415	$10.00	$3.75
August 13, 2018	CPT Code 80053	$91.00	$16.30
TOTAL		$512.00	$232.45

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 (DWC).

Background

1. 28 Texas Administrative Code §133.307, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §122.3, effective October 15, 1997, sets out the procedures for Exposure to Communicable Diseases: Reporting and Testing Requirements for Emergency Responders.
3. Health and Safety Code Title 2. Health Subtitle D. Prevention, Control, And Reports Of Diseases, Chapter 81, Communicable Diseases , Subchapter A. General Provisions, Section 81.050, effective September 1, 1991.
4. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
5. 28 Texas Administrative Code §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
6. 25 Texas Administrative Code § 97.12 (i)(4) refers to the "postexposure medical follow-up as recommended by the United States Public Health Service." The updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis may be found at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5011a1.htm
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16-Claim/service lacks information which is needed for adjudication. Additional information is supplies using remittance advice remarks codes whenever appropriate.
   - 309-The charge for the procedure exceeds the fee schedule allowance.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 6553-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - P13-Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable.
   - W3-Additional payment made on appeal/reconsideration.
   - 5080-Based on the receipt of additional information and/or clarification, we are recommending further payment be made for the above noted procedure code(s).
   - 6549-Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable.

Issues

Is the respondent's denial of payment for professional services rendered to the injured employee on May 7 and August 13, 2018 supported? Is the requestor entitled to reimbursement?

Findings

1. Dr. David R. Long (requestor) is seeking dispute resolution in the amount of $512.00 for professional services rendered to the injured employee on May 7 and August 13, 2018.
2. The State Office of Risk Management (respondent) wrote in response to this dispute, "There is no evidence provided to the carrier that the injured employee sustained an injury as defined in Texas Labor Code

§408.011(26); Therefore, the carrier reimbursed all initial testing that was performed on 2/08/2018."

28 TAC §133.307(d)(2)(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 DWC finds that the respondent raises issues in the position summary that were not presented to the requestor prior to the date the request for MFDR was filed with the DWC. A review of the submitted explanation of benefits does not list any denial reasons disputing the injured employee sustained an injury; therefore, the response was not submitted in accordance with 28 TAC §133.307(d)(2)(F).

3. Laboratory Testing:

The respondent initially denied reimbursement for the disputed laboratory testing based upon a lack of documentation. Upon reconsideration, the respondent wrote, "Based on the receipt of additional information and/or clarification, we are recommending further payment be made for the above noted procedure code(s)." The DWC concludes the denial based upon a lack of documentation has been resolved.

The respondent also denied reimbursement for the disputed laboratory testing based upon "P13-Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable." The DWC finds the respondent did not specify which regulations or payment policies the denial of payment was based upon.

On February 7, 2018, the injured employee was working at Preston Smith Unit TDCJ and sustained a laceration to her right pinky finger resulting in exposure to bodily fluids. The DWC finds 28 TAC §122.3(a) applies to this dispute.

28 TAC §122.3(a) states, "This section applies to all law enforcement officers, fire fighters, emergency medical service employees, paramedics, and correctional officers who are either state employees or employees covered under workers' compensation insurance (to include those who are providing services as a volunteer and are covered by workers' compensation insurance)."

Health And Safety Code Title 2. Health Subtitle D. Prevention, Control, And Reports Of Diseases, Chapter 81, Communicable Diseases , Subchapter A. General Provisions, Section 81.050 (b) titled Mandatory Testing Of Persons Suspected Of Exposing Certain Other Persons To Reportable Diseases, Including HIV Infection, states, "A person whose occupation or whose volunteer service is included in one or more of the following categories may request the department or a health authority to order testing of another person who may have exposed the person to a reportable disease: (4) a correctional officer; and (5) an employee, contractor, or volunteer, other than a correctional officer, who performs a service in a correctional facility as defined by Section 1.07, Penal Code, or a secure correctional facility or secure detention facility as defined by Section 51.02, Family Code."

28 TAC §122.3(c) states, "An employee listed in subsection (a) of this section will not be entitled to workers' compensation benefits for a reportable disease unless the employee:
(1) had a test performed within 10 days of an exposure to the reportable disease that indicated the absence of the reportable disease (Exposure criteria and testing protocol must conform to Texas Department of Health requirements. This rule does not prohibit a decision-maker's consideration of other factors.); and (2) provided the employer with a sworn affidavit of the date and circumstances of the exposure and a copy of the results of the test required by paragraph (1) of this subsection."

25 TAC § 97.12 (i)(4) refers to the "postexposure medical follow-up as recommended by the United States Public Health Service." The updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis may be found at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5011a1.htm

The Centers for Disease Control and Prevention (CDCs), Morbidity and Mortality weekly report titled Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis, June 29, 2001 / 50(RR11);1-42, Management of Exposures to HCV, "For the person exposed to an HCV-positive source perform baseline testing for anti-HCV and ALT activity; and perform follow-up testing (e.g., at 4--6 months) for anti-HCV and ALT activity (if earlier diagnosis of HCV infection is desired, testing for HCV RNA may be performed at 4--6 weeks)."

28 TAC §122.3 (d) states, "The employer's insurance carrier, including state and political subdivision employers, shall be liable for the costs of test(s) required by subsection (c) of this section, regardless of the results of the test(s), in addition to any other benefits required to be paid by the Texas Workers' Compensation Act or administrative rules. The cost of a state employee's testing, regardless of the results of the test, shall be paid from funds appropriated for payment of workers' compensation benefits to state employees."

A review of the office visit report supports billed laboratory service; therefore, reimbursement is recommended.

28 TAC §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."

28 Texas Administrative Code §134.203(e) states, "The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service."

A review of the Medicare Clinical Laboratory Fee Schedule finds the following:

Date	Code	Medicare Clinical Laboratory Fee Schedule Rate	MAR	Insurance Carrier Paid	Total Due
May 7, 2018	86704	$14.88	$18.60	$0.00	$18.60
	86708	$15.29	$19.11	$0.00	$19.11
	86803	$17.61	$22.01	$0.00	$22.01
	87340	$12.75	$15.93	$0.00	$15.93
	86703	$16.92	$21.15	$0.00	$21.15
August 13, 2018	36415	$3	$3.75	$0.00	$3.75
	80053	$13.04	$16.30	$0.00	$16.30
TOTAL					$116.85

4. Office Visit:

The requestor billed for an office visit rendered on August 13, 2018. The respondent denied reimbursement based upon "P13-Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable." The DWC finds the respondent did not specify which regulations or payment policies the denial of payment was based upon. A review of the office visit report supports billed service; therefore, reimbursement is recommended.

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 Lubbock, Texas; therefore, the locality will be based on the rate for "Rest of Texas".

Using the above formula, the DWC finds:

Date	Code	Medicare Fee Schedule	MAR	Insurance Carrier Paid	Total Due
August 13, 2018	99213	$71.37	$115.60	$0.00	$115.60

5. Work Status Report:

The requestor billed for a work status report rendered on August 13, 2018. The respondent denied reimbursement based upon P13-Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable."

28 TAC §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 TAC §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 TAC §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.”

The requestor did not submit a copy of the work status report to support billing in accordance with 28 TAC §129.5. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $232.45.

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 DWC hereby ORDERS the respondent to remit to the requestor $232.45, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	10/14/2019 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, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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. **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.