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
IAN J REYNOLDS MD PA

Respondent Name
NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number
M4-19-5048-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 30, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Cpt code 99204 is accurate coding for this particular patient. I believe the denial for this code is an automatic just so the insurance company can save money. They seem to only want to pay for 99203. Unless they are in the room with the doctor and the patient they should have no right to determine the level of service that is being billed. Insurance company needs to pay services as billed."

Amount in Dispute: $332.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No response was received.

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
May 3, 2019	99204	$332.00	$263.10

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 150 – Payer deems the information submitted does not support this level of service
   - P12 – Workers compensation jurisdiction fee schedule adjustment
   - W3 – Request for reconsideration

Issue(s)

1. Did the insurance carrier respond to the medical fee dispute?
2. Does the documentation support the billing of CPT code 99204?
3. Is the requestor entitled to reimbursement?

Findings

1. The Austin carrier representative for New Hampshire Insurance Company is Flahive Ogden & Latson. Flahive Ogden & Latson acknowledged receipt of the copy of this medical fee dispute on August 6, 2019. 28 TAC §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under 28 TAC §133.307(d)(1).

2. The insurance carrier denied reimbursement for CPT code 99204, with denial reason code "150-Payer deems the information submitted does not support this level of service."

   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."

   CPT code 99204 is described as "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or 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 moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.."

   A review of the submitted medical report supports the billing of CPT Code 99204; therefore, the insurance carrier's denial reason is not supported, and the requestor is entitled to reimbursement for CPT Code 99204.

3. Per 28 TAC §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. ..."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   - The 2019 DWC conversion factor for this service is 59.19.
   - The Medicare Conversion Factor is 36.0391
   - Review of Box 32 on the CMS-1500 the services were rendered in Beaumont, Texas; therefore, the locality will be based on the rate for "Beaumont Texas".
   - The Medicare participating amount for CPT Code 99204 is $160.19.

Procedure code 99204, rendered on May 3, 2019, has a Work RVU of 2.43 multiplied by the Work GPCI of 1 is 2.43. The practice expense RVU of 1.99 multiplied by the PE GPCI of 0.924 is 1.83876. The malpractice RVU of 0.21 multiplied by the malpractice GPCI of 0.839 is 0.17619. The sum is 4.44495 multiplied by the DWC conversion factor of $59.19 for a MAR of $263.10.

The DWC finds that the requestor is entitled to reimbursement in the amount of $263.10, therefore this amount is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $263.10.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of TLC Sections 413.031 and 413.019 (if applicable), the DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of $263.10 plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this Order.

Authorized Signature

______________________	______________________	September 30, 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 28 TAC §133.307, 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 with the DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.