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
UT HEALTH CENTER TYLER

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-19-5056-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
July 30, 2019

Response Submitted By
State Office of Risk Management

REQUESTOR'S POSITION SUMMARY

"Per our Texas Fee Schedule calculations, this bill has been underpaid."

RESPONDENT'S POSITION SUMMARY

"the medical documentation submitted supports the visit was for a Maximum Medical Improvement and Impairment evaluation whereas the provider failed to bill the correct CPT codes pursuant to Rule 134.250."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 5, 2018	Outpatient Clinic Evaluation Services	$227.38	$203.42

AUTHORITY

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 (DWC).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the hospital facility fee guideline for outpatient services.
3. 28 Texas Administrative Code §126.6 sets out provisions regarding required medical examinations.
4. 28 Texas Administrative Code §133.10 specifies required billing forms and formats.
5. 28 Texas Administrative Code §134.209 specifies the applicability for workers' compensation specific services.
6. 28 Texas Administrative Code §134.250 sets out reimbursement for Maximum Medical Improvement Exams.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 4 – THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.

   With additional claims adjustment advice: "Attached DWC 69 and clinical supports service of MMI exam. Please submit appropriate CPT code and modifier for MMI exam done by treating doctor per rule 134.204."

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied the disputed service with claim adjustment reason code 4 – "The procedure code is inconsistent with the modifier used or a required modifier is missing."; with additional claims adjustment advice: "Attached DWC 69 and clinical supports service of MMI exam. Please submit appropriate CPT code and modifier for MMI exam done by treating doctor per rule 134.204."

   The division notes the denial reason on the carrier's explanation of benefits (EOB) refers to 28 Texas Administrative Code §134.204 — a rule which was not effective on the date of service. Former Rule 28 TAC §134.204 has been replaced by Rules 28 TAC §134.209, regarding applicability; and §134.250, regarding Maximum Medical Improvement Evaluations and Impairment Rating (MMI/IR) Examinations, effective for services provided on or after September 1, 2016.

   Rule 28 TAC §134.209(a)(4) specifies that the above payment rules apply to workers' compensation specific codes, services, and programs "other than the facility services of a hospital or other health care facility."

   The division notes further that the disputed service was billed on an institutional billing form UB-04, appropriate for billing outpatient hospital clinic services under 28 TAC §133.10 regarding required billing forms and formats.

   Consequently, per 28 TAC §134.209(a)(4), the payment provisions of 28 TAC §134.250 are not applicable to the disputed hospital or health care facility services.

   The respondent, State Office of Risk Management (SORM) asserts, "the medical documentation submitted supports the visit was for a Maximum Medical Improvement and Impairment evaluation whereas the provider failed to bill the correct CPT codes pursuant to Rule 134.250."

   Review of the submitted documentation finds the injured employee was seen at an outpatient facility clinic for assessment after successfully completing a course of physical therapy. The medical record notes the employee "achieved all… goals" and was "back to baseline with no pain." As a result of the evaluation, the employee was discharged from care, released back to work and okayed for full duty.

   Review of the submitted documentation finds the provider met the requirements for billing disputed HCPCS code G0463 — defined as a hospital outpatient clinic visit for assessment and management of a patient (without distinction between new and established patients or levels of care).

   Additionally, the provider completed form DWC069, *Report of Medical Evaluation*, in the capacity of the treating doctor (as marked on the form), certifying the employee's clinical maximum medical improvement (MMI) without impairment. The doctor also completed DWC Form-73, *Work Status Report*, authorizing the employee to return to work without restrictions. However, the provider did not bill for either of these two services.

   The division notes the examination was not a *Required Medical Examination* and was not ordered by DWC under Rule 28 TAC §126.6 (regarding MMI/IR examinations ordered by DWC).

   SORM presents selected text of Rule 28 TAC §134.250 regarding payment for Maximum Medical Improvement Evaluations and Impairment Rating Examinations (MMI/IR) to support their position that the services were improperly billed. However, review of the submitted information found no DWC rule requiring the provider to bill the dispute services as an MMI/IR examination. The insurance carrier's denial reasons are not supported.

   DWC concludes the submitted documentation supports the evaluation service as billed. The disputed service will therefore be reviewed for payment in accordance with DWC rules and fee guidelines.

2. This dispute regards outpatient facility services subject to DWC's *Hospital Facility Fee Guideline*, 28 TAC §134.403, which requires the maximum allowable reimbursement (MAR) be the Medicare facility specific amount applying Medicare Outpatient Prospective Payment System (OPPS) formulas and factors modified by DWC rules.

   28 TAC §134.403(f)(1) requires the Medicare facility specific amount be multiplied by 200% for this disputed service. Medicare assigns an Ambulatory Payment Classification (APC) to OPPS services based on billed procedure codes and supporting documentation. The APC determines the payment rate. Reimbursement for ancillary items and services is packaged with the APC payment. CMS publishes quarterly APC rate updates, available at www.cms.gov.

Reimbursement is calculated as follows:

- Procedure code G0463 represents an outpatient clinic visit for assessment and management of a patient. This code is assigned APC 5012, with an OPPS Addendum A rate of $113.69. This is multiplied by 60% for an unadjusted labor amount of $68.21, and in turn multiplied by the facility wage index of 0.8244 for an adjusted labor amount of $56.23. The non-labor portion is 40% of the APC rate, or $45.48. The sum of the labor and non-labor portions is the Medicare facility specific amount of $101.71. This is multiplied by 200% for a MAR of $203.42.

The total recommended reimbursement for the disputed services is $203.42. The insurance carrier paid $0.00. The amount due is $203.42. 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 findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above, the requestor has established that additional payment is due. As a result, the amount ordered is $203.42.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable), based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $203.42, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	October 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 28 TAC §133.307.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). DWC must receive the request within twenty days of your receipt of this decision.

You may fax, mail or personally deliver the request to either the field office handling the claim or to DWC at the contact information on the form. You must send a copy to all other parties in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** along with any other information required by 28 TAC §141.1(d).

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