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
CLINICS OF NORTH TEXAS

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-20-2430-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
JUNE 8, 2020

REQUESTOR'S POSITION SUMMARY

"I have audited the claim and it audits at a level 99214 as billed. I have included my audit in this packet. Please reprocess the claim for payment."

Amount in Dispute: $790.00

RESPONDENT'S POSITION SUMMARY

"Audit staff reviewed the documentation and though 3 key components of the criteria are noted, audit staff noted that level of severity does not appear to be moderate to severe in nature as noted per the AMA

CPT coding book description for high level office visit."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 30, 2019	CPT Code 99214 Office Visit	$255.00	$174.55
November 6, 2019	CPT Code 99080-73 Work Status Report	$25.00	$0.00
	CPT Code 99214 Office Visit	$255.00	$174.55
March 4, 2019	CPT Code 99214 Office Visit	$255.00	$177.89
TOTAL		$790.00	$526.99

FINDINGS AND DECISION

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

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.239, effective July 7, 2016, sets out medical fee guidelines for workers' compensation specific services.
3. 28 TAC §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
4. 28 TAC §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.
   - CAC-150-Payer deems the information submitted does not support this level of service.
   - CAC-16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - CAC-18-Exact duplicate claim/service.
   - 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
   - 248-DWC-73 in excess of filing requirements; no change in work status and/or restrictions; reimbursement denied per rule 129.5.
   - 890-Denied per AMA CPT code description for level of service and/or nature of presenting problems.
   - CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
   - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 891-No additional payment after reconsideration

Issues

Does the documentation support billing CPT code 99214 and 99080-73? Is the requestor due reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $790.00 for CPT codes 99214 and 99080-73 rendered from September 30, 2019 through March 4, 2020.
2. The insurance carrier denied reimbursement for the office visit , CPT code 99214, based upon reason codes "CAC-150-Payer deems the information submitted does not support this level of service," "CAC-16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication," "225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information, "and "890-Denied per AMA CPT code description for level of service and/or nature of presenting problems."
3. The fee guidelines for disputed services are found in 28 TAC §134.203.

   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."
4. CPT code 99214 is described as "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed

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, 25 minutes are spent face-to-face with the patient and/or family."

A review of the submitted medical report supports two of the three key components required for billing code 99214, specifically a detailed history and examination; therefore, reimbursement is recommended.

5. 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. The following hypothetical example illustrates this annual adjustment activity if the DWC had been using this MEI annual percentage adjustment: The 2006 DWC 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) DWC conversion factor in 2007."

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

   DOS September 30, and November 6, 2019:

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

   The Medicare Participating amount for CPT code 99214 at this locality is $106.28.

   Using the above formula, the MAR is $174.55. The respondent paid $0.00. As a result, the requestor is due $174.55 X 2 DOS = $349.10.

   DOS March 4, 2020:

   The 2020 DWC Conversion Factor is 60.32

   The 2020 Medicare Conversion Factor is 36.0896

   Review of Box 32 on the CMS-1500 the services were rendered in Wichita Falls, Texas; therefore, the locality will be based on the rate for "Rest of Texas".

   The Medicare Participating amount for CPT code 99214 at this locality is $106.43.

   Using the above formula, the DWC finds the MAR is $177.89. The respondent paid $0.00. As a result, reimbursement of $177.89 is recommended.

6. CPT code 99080-73 is described as "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form."

   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."

A review of the submitted documentations finds the requestor did not submit a copy of the DWC-73 report to support billing. 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 $526.99.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code 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 $526.99 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		07/09/2020
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 Texas Administrative Code §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 MDR 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 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.