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
North Texas Rehabilitation Center

Respondent Name
Texas Hospital Insurance Exchange

MFDR Tracking Number
M4-20-2901-01

Carrier's Austin Representative
Box Number 6

MFDR Date Received
August 12, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have tried a number of time to get our bills paid but, the carriers are not following the 'Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to COVID-19 Public Health Emergency'."

Amount in Dispute: $1,260.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Texas Labor Code and Division of Workers Comp Rules state the health care provider must use Place of Service (POS) code 02 to indicate that the service was delivered via telehealth/telemedicine."

Response Submitted by: Injury Management Organization, Inc

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 13 – 27, 2020	Professional Medical Services	$1,260.00	$0.00

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.

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 reimbursement guidelines for professional medical

services.
3. 28 Texas Administrative Code §167.1 details requirements of telemedicine.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 58 – Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate on invalid place of service
   - 193 – Original payment decision is being maintained, upon review, it was determined that this claim was processed properly

Issues

Is the insurance carrier's denial of payment supported?

Findings

The requestor is seeking reimbursement of $1,260.00 for professional medical services rendered in April 2020 through telehealth. The insurance carrier denied the disputed services based on invalid place of service.

Review of the submitted medical bill found the requestor used place of service 11 with code 97799 , modifier 95, MR, CA. The requestor states in their position statement, "…we are filing because of the New Rules regarding the "Place of Service and Modifier 95".

While the Division of Workers' Compensation follows Medicare guidelines regarding coding, 28 TAC 134.203 (a)(7) states in pertinent part, specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by CMS in administering the Medicare program.

DWC issued a COVID-19 Emergency Rule 167.1 on April 13, 2020 regarding telehealth at www.tdi.texas.gov/wc/rules/adopted/documents/er167tm0420.pdf which states in part:

> ***Health care providers must bill for telemedicine or telehealth services using the same billing, coding, reporting, and documentation requirements used for in-person services and include a place of service code "02 – telehealth" on the bill.***

The requestor submitted Code 97799. Review of the Medicare Covered Telehealth services at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes, did not find the disputed code (97799) is a covered telehealth code.

The place of service reported was contrary to DWC guidelines. The disputed code is not on the covered telehealth services, no payment is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC 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 not established payment is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		November , 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 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to 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 TAC §141.1(d).

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