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
FUNCTIONAL RECOVERY ASSOCIATES

Respondent Name
AMERICA FIRST LLOYDS INSURANCE COMPANY

MFDR Tracking Number
M4-21-1070-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
March 1, 2021

Response Submitted by:
Liberty Mutual Insurance Company

REQUESTOR'S POSITION SUMMARY

"Under the Texas Department of Insurance (TDI) emergency rule, state-regulated health insurers and health maintenance organizations must: Pay in-network health professionals at least the same rate for the telemedicine services as for in-person services, including covered mental health services. Cover telemedicine services using any platform permitted by state law. Not require more documentation for telemedicine services than they require for in-person services. The rule does not affect how the claim for the service should be coded or submitted. Claims must use the codes reflecting the services actually provided and the method of care delivery actually used… It is our position that the charges are reasonable and well within the usual and customary charge for this type of procedure. Therefore, we request immediate reconsideration of the reduction of charges."

RESPONDENT'S POSITION SUMMARY

"We have reviewed the bills in question and find that the payment is appropriate as The Division's emergency rule (28 TEX. ADMIN, CODE §167, 1) states that Providers must bill for telehealth services in the same fashion as they would bill for in-person services, The Division's emergency rule specifies that Providers must use the POS code 02, which defaults to facility reimbursement rates. The CMS interim change allows a Provider to change the POS code to better reflect the place where the service would have been delivered were it to have taken place in person. The modifier 95 allows the provider to code the service as telehealth, a notification made necessary as POS 02 would not be Included on the bill. The Provider, in its request for reconsideration, refers to Emergency Rule 28 TEX. ADMIN, CODE §35.1. However, that Emergency Rule applies to Health Benefit Plans as specified in sections 1455.002 and 1455.003 of the Texas Insurance Code, which specifically do not apply to a workers' compensation Insurance policy, Tex. Ins. Code §1455.003(4)."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 22, 2020 through August 19, 2020	99213-95 x 4	$246.27	$162.40

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 (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 TAC §133.30 sets out the Telemedicine and Telehealth Services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 170 – Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting.
   - 3452 – Modifier 95-synchronous telemedicine services rendered via real-time interactive audio and video telecommunications system.
   - W3 – Additional payment made on appeal/reconsideration.

Issues

Is the insurance carrier's reduction of payment supported?

Findings

The requestor seeks reimbursement of $246.27 for professional medical services rendered on April 22, 2020 through August 19, 2020. The insurance carrier reduced the payment amount with reduction code "170 – Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting."

Review of the submitted medical records, titled, "RECHECK OFFICE ASSESSMENT" documents that the patient gave verbal consent to a telemedicine visit. The requestor documented each office visit as a telemedicine visit.

Per 28 TAC §133.30 a health care provider may bill and be reimbursed for telemedicine and telehealth services regardless of the geographical area or location of the injured employee. Telehealth and telemedicine services are billed as professional services. Reimbursement for professional services is established by the Medical Fee Guideline for Professional Services, 28 TAC §134.203.

28 TAC §134.203(b)(1) states in part "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules." The requestor's supplemental position statement references the CMS Interim Final Rule 19230-01 stating "According to that rule, the reimbursement rates for in person medical visits and the reimbursement rates for telemedicine visits are the same. Since the Medicare reimbursement rates are the basis for Worker's Compensation payments in Texas, the attached rule controls." Review of the CMS Interim Final Rule 19230, effective March 31, 2020, finds that Medicare changed the reimbursement rates for telemedicine services to health care providers from the facility rate to the non-facility rate.

28 TAC §134.203 (a)(7) states that specific Texas Labor Code provisions and division rules take precedence over conflicting CMS provisions administering Medicare. The division finds no provisions in the Labor Code or its adopted rules that conflict with the CMS Interim Final Rule 19230. As there are no conflicts, the maximum allowable reimbursement (MAR) for telemedicine services provided in the workers' compensation services follow Medicare payment policies. As Medicare reimburses telemedicine services under the non-facility rate per Interim Final Rule 19230, the division finds that the MAR for telemedicine services is calculated using the non-facility rate.

DWC now considers whether the disputed services are covered telemedicine or telehealth services. Review of the Medicare Covered Telehealth services at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes, found that the disputed services are CPT Codes listed in the covered telehealth code list. The disputed codes are therefore subject to reimbursement pursuant to 28 TAC §134.203.

28 TAC §134.203 (c)(1)(2) states in pertinent part, "To determine the Maximum Allowable Reimbursement (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. ..."

Reimbursement is calculated as follows:

DOS	CPT CODE	# UNITS	AMOUNT PAID	MAR	MAR - Amount Paid = Amount Due	DISPUTED AMOUNT	AMOUNT DUE
4/22/20	99213-25	1	$87.35	$127.95	$127.95 - $87.35 = $40.60	$94.32	$40.60
5/19/20	99213-95	1	$87.35	$127.95	$127.95 - $87.35 = $40.60	$50.65	$40.60
6/17/20	99213-95	1	$87.35	$127.95	$127.95 - $87.35 = $40.60	$50.65	$40.60
8/19/20	99213-95	1	$87.35	$127.95	$127.95 - $87.35 = $40.60	$50.65	$40.60
TOTAL			$349.40	$511.80	$162.40	$246.27	$162.40

Per 28 TAC §134.203 (h)(1-2), "…When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; (3) fair and reasonable amount consistent with the standards of §134.1 of this title." The DWC finds that the requestor is entitled to a total recommended amount of $162.40.

Conclusion

In resolving disputes over reimbursement, 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 established that additional payment in the amount of $162.40 is due. As a result, the amount ordered is $162.40.

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 Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $162.40 plus applicable accrued interest per 28 TAC §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 13, 2021 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, 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.