



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

TOM G. MAYER, MD

Respondent Name

SWISS REINSURANCE AMERICA CORPORATION

MFDR Tracking Number

M4-21-2143-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

July 21, 2021

Response Submitted by:

Flahive, Ogden & Latson

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 are attaching a copy of the carrier's EOBs dated November 11, 2020 and December 18, 2020. It is the carrier's position that the provider was reimbursed pursuant to Medical Fee Guidelines and that the provider is not entitled to any additional reimbursement."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 24, 2020	99213-95	\$50.65	\$40.60

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 §133.30 sets out the Telemedicine and Telehealth Services.

4. 85 Federal Register 19230-01 Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency sets out changes to made to telemedicine and telehealth services under Medicare.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 790 – This charge was reimbursed in accordance with the Texas Medical Fee Guideline.
 - P12 – Workers Compensation jurisdictional fee schedule adjustment.

Issues

Is the insurance carrier’s reduction of payment supported?

Findings

The requestor seeks reimbursement of \$50.65 for CPT Code 99213-95 rendered on September 24, 2020. The insurance carrier issued a payment in the amount of \$87.35 and denied the remaining amount with reduction codes 790 and P12 (description provided above.)

Review of the submitted medical records, titled, “RECHECK OFFICE ASSESSMENT” documents that the patient gave verbal consent to a telemedicine visit. The requestor documented the 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
09/24/2020	99213-95	1	\$87.35	\$127.95	\$127.95 - \$87.35 = \$40.60	\$50.65	\$40.60
TOTAL			\$87.35	\$127.95	\$40.60	\$50.65	\$40.60

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 \$40.60.

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 stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$40.60.

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 reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$40.60 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

August 26, 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).