



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

IKECHUKWU OBIH, MD

Respondent Name

TX PUBLIC SCHOOL WC PROJECT

MFDR Tracking Number

M4-21-2153-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received O

JULY 22, 2021

REQUESTOR'S POSITION SUMMARY

"WORK COMP TREATMENT AND SERVICES NO PAYMENT RECEIVED...The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134."

Amount in Dispute: \$402.22

RESPONDENT'S POSITION SUMMARY

"CRF contends that Dr. Obi's narrative report fails to document that the services in question were performed via telemedicine and that the patient gave verbal consent to a telemedicine visit. Accordingly, Dr. Obi's narrative report fail to substantiate the occurrence of a telemedicine visit."

Response Submitted By: Creative Risk Funding

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 30, 2021	CPT Code 99205-95 Office Visit-Telemedicine	\$402.22	\$0.00

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/denied payment for the disputed services with the following claim adjustment codes:
 - 150-Payer deems the information submitted does not support this level of service.
 - 16-Claim/service lacks information or has submission billing error(s).
 - Medical documentation does not support telemedicine.
 - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - 4-The procedure code is inconsistent with the modifier used or a required modifier is missing.
 - 5-The procedure code/type of bill is inconsistent with the place of service.
 - W3-Reconsideration/Appeal
 - Provider has billed with place of service 02,Home< And modifier 95 for telemedicine medical documentation. Received does not support telemedicine services.

Issues

Is the requestor due reimbursement for CPT code 99205-95 rendered on March 30, 2021?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of \$402.22 for CPT code 99205-95 rendered on March 30, 2021.
2. The insurance carrier denied reimbursement for the disputed services based upon reason codes "150," "16," "4," and "5" (description above).
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 99205 is described as "Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter."

The requestor appended modifier "95- Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System." Modifier 95 is defined as "Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements

of the same service when rendered via a face-to-face interaction. Modifier 95 may only be appended to the services listed in Appendix P. Appendix P is the list of CPT codes for services that are typically performed face-to-face, but may be rendered via real-time (synchronous) interactive audio and video telecommunications system.”

A review of the submitted medical report indicates the “TIME IN: 09:30AM” “TIME OUT: 10:10 AM,” for a total of 40 minutes. The DWC finds the requestor supported 40 minutes of total time. The requestor did not note that this was a telemedicine visit to support billing modifier 95. The DWC concludes the requestor did not support billing CPT code 99205-95, as a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the DWC has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

08/24/2021
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 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.