TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
JOHN I. OBIH, MD

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-21-2417-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
August 25, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 5, 2021	99203-95	$52.52	$52.52
	Total	$52.52	$52.52

Requestor's Position

"Work Comp Treatment/Services incorrect reduction."

Amount in Dispute: $52.52

Respondent's Position

"The requestor billed E/M code 99203-95 with place of service 02 for telemedicine. To determine the reimbursement rate Texas Mutual took the DWC Conversion factor $61.17 divided by 34.8931 Medicare Conversion Factor then took that amount 1.753068658273412 and multiplied by the Physician Fee Schedule Facility price $86.38 and paid $151.53. "

Response Submitted by: Texas Mutual Insurance Company

Findings and Decision

Authority

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

Statutes and Rules

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.

Denial Reasons

The insurance carrier reduced or denied the 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.
- 891 – No additional payment after reconsideration.

Issues

Is the Insurance carrier's reduction supported?

Findings

The requestor seeks additional reimbursement of $52.52 for CPT Code 99203-95 rendered on May 5, 2021. The insurance carrier reduced the payment amount with reduction code 790, P12 and 891 (description provided above). The requestor billed for a telemedicine service, identified by the -95-modifier appended to the CPT Code, 99203.

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
5/5/21	99203-95	1	$151.43	$204.30	$204.30 - $151.43 = $52.87	$52.52	$52.52
TOTAL			$151.43	$204.30	$52.87	$52.52	$52.52

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 $52.52.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement of $52.52 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. The Division hereby ORDERS the respondent to remit to the requestor the amount of $52.52 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	September 23, 2021 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.