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

General Information

Requester Name
UNIMED HEALTH CARE INC.

Respondent Name
CITY OF HOUSTON

MFDR Tracking Number
M4-22-0211-01

Carrier's Austin Representative
Box Number 29

MFDR Date Received
October 4, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 6, 2020 through November 12, 2020	90837 x 5	$2,000.00	$1,207.92
	Total	$2,000.00	$1,207.92

Requester's Position

"We respectfully would like to appeal this DOS Attached preauthorization letter, notes, eob and hicfas..."

Amount in Dispute: $2,000.00

Respondent's Position

"Documentation provided with the bill did not support services were performed in a telemedicine setting. The modifier was not corrected and was received as reconsideration. Therefore, our response is the bill was denied appropriately due to incorrect billing of the modifier for services rendered."

Response Submitted by: IMO

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).

Statues 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:

- W3 - RECONSIDERATION
- 193 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 1014 - THE ATTACHED BILLING HAS BEEN RE-EVALUATED AT THE REQUEST OF THE PROVIDER. BASED ON THIS RE-EVALUATION, WE FIND OUR ORIGINAL REVIEW TO BE CORRECT. THEREFORE, NO ADDITIONAL ALLOWANCE APPEARS TO BE WARRANTED.
- 58 – PAYMENT ADJUSTED BECAUSE TREATMENT WAS DEEMED BY THE PAYER TO HAVE BEEN RENDERED IN AN INAPPROPRIATE OR INVALID PLACE OF SERVICE

Issues

Is the insurance carrier's reduction of payment supported?

Findings

The requestor seeks reimbursement of $2,000.00 for CPT code 90837 rendered on October 6, 2020 through November 12, 2020. The insurance carrier reduced the payment amount with reduction code "58" (description provided above.)

Review of the submitted medical records, titled, "INDIVIDUAL COUNSELING" documents the following "Completed by telehealth." The requestor documented the counseling sessions as telehealth visits. As a result, the insurance carrier's denial reason is not supported.

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 CMS Interim Final Rule 19230-01 states "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… (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
10/6/2020	90837-95	1	$0.00	$241.58	$241.58 - $0.00 = $241.58	$400.00	$241.58
10/12/2020	90837-95	1	$0.00	$241.58	$241.58 - $0.00 = $241.58	$400.00	$241.58
10/26/2020	90837-95	1	$0.00	$241.58	$241.58 - $0.00 = $241.58	$400.00	$241.58
11/10/2020	90837-95	1	$0.00	$241.58	$241.58 - $0.00 = $241.58	$400.00	$241.58
11/12/2020	90837-95	1	$0.00	$241.58	$241.58 - $0.00 = $241.58	$400.00	$241.58
TOTAL			$0.00	$1,207.92	$1,207.92	$2,000.00	$1,207.92

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 $1,207.92.

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 reimbursement of $1,207.92 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to Requester $1,207.92 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		October 26, 2021
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 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 512-804-4812.