TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
BRENT DALE DREIER, DC

Respondent Name
OLD REPUBLIC INSURANCE COMPANY

MFDR Tracking Number
M4-22-0748-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
December 20, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 20, 2021	98940, 98943 and 99213	$133.00	$101.00
	Total	$133.00	$101.00

Requestor's Position

"Billed for $133.00 for DOS 07/20/2021 and paid $0.00. I have sent this claim in for reconsider with a corrected claim, but the claim has still not been paid. We feel that this claim should be paid because this is a workers' compensation claim. Please review this promptly and thank you for your time in this matter."

Amount in Dispute: $133.00

Respondent's Position

The Austin carrier representative for Old Republic Insurance Company is White Espey PLLC. White Espey PLLC., was notified of this medical fee dispute on December 29, 2021. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

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 fee guideline for professional medical services.
3. 28 TAC §134.600 sets out the preauthorization requirements for specific treatments and services.
4. 28 TAC §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
5. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines
6. 28 TAC §137.100, effective January 18, 2007, sets out the use of the treatment guidelines.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3 – Bill is a reconsideration or appeal.
- 197 – Payment denied/reduced for absence of precertification/authorization.

Issues

1. Are the insurance carrier's denial reasons supported?
2. What are the definitions for CPT Codes 99213, 98940, and 98943?
3. Did the requestor submit sufficient documentation to support the reimbursement for CPT Code 98943?
4. What rules apply to reimbursement for CPT Codes 99213 and 98940?
5. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Codes 98940, 98943 and 99213 rendered on July 20, 2021. The insurance carrier denied the service in dispute with denial reduction codes 193, W3 and 197 (description provided above.)

   The insurance carrier did not respond to the DWC060 request. The requestor states, "We feel that this claim should be paid because this is a workers' compensation claim."

   Per 28 TAC §134.600 (p)(12 the non-emergency healthcare that requires preauthorization includes: "treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier…."

According to the Neck and Upper Back Chapter of the Official Disability Guidelines (ODG), manipulations are recommended; therefore, the disputed manipulations, CPT codes 98940 and 98943 do not require preauthorization.

Per 28 TAC §134.600 (p), preauthorization is not required for evaluation and management services. As a result, the DWC finds that the insurance carrier's denial reason is not supported, and the requestor is therefore entitled to reimbursement for CPT Code 99213.

2. 28 TAC §134.203(b)(1) states, "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 billed CPT Codes 98940, 98943 and 99213. The AMA CPT codes descriptions are as follows:

   - CPT Code 98940 – Chiropractic manipulative treatment (CMT); spinal, 1-2 regions
   - CPT Code 98943 – Chiropractic manipulative treatment (CMT); spinal, 3-4 regions
   - CPT Code 99213 – Established patient office or other outpatient visit, 20-29 minutes.

   The DWC finds that CPT Codes 99213 and 98940 are both priced by Medicare, and subject to 28 TAC §134.203(c).

   The DWC finds that CPT Code 98943 is not priced by Medicare and therefore subject to 28 TAC §134.203 (f) and 28 TAC §134.1.

3. Because CPT code 98943 is not priced by Medicare the division refers to 28 TAC §134.203(f) which states, "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)."

   28 TAC §134.1, effective March 1, 2008, 33 Texas Register 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(f) which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."

   Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

The requestor is seeking $32.00 for CPT Code 98943. 28 TAC §133.307(c)(2)(O), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable."

A review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought of $32.00 for CPT Code 98943 would be a fair and reasonable rate of reimbursement. As a result, reimbursement cannot be recommended.

4. The requestor seeks reimbursement for CPT Codes 99213 and 98940.

   28 TAC §134.203 states in pertinent part, "(c) To determine the 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..."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

   - The 2021 DWC Conversion Factor is 61.17
   - The 2021 Medicare Conversion Factor is 34.8931
   - Per the medical bills, the services were rendered in Cuero, TX; therefore, the Medicare locality is "Rest of Texas."

   The Medicare Participating amount for CPT code 99213 at this locality is $89.05.
   - Using the above formula, the DWC finds the MAR is $156.11.
   - The respondent paid $0.00.
   - The requestor seeks $65.00.
   - Reimbursement of $65.00 is recommended.

   The Medicare Participating amount for CPT code 98940 at this locality is $27.58.
   - Using the above formula, the DWC finds the MAR is $48.35.
   - The respondent paid $0.00.
   - The requestor seeks $36.00.
   - Reimbursement of $36.00 is recommended.

5. The DWC finds that the requestor is therefore entitled to a total recommended amount of $101.00.

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.

The DWC finds the requester has established that reimbursement of $101.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor $101.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		March 21, 2022
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 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.