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
ELITE HEALTHCARE GARLAND

Respondent Name
INDEMNITY INSURANCE COMPANY

MFDR Tracking Number
M4-22-0914-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
January 22, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 15, 2021 through May 27, 2021	99361-W1 x 2, 99213 x 2 and 99080-73 x 2	$582.28	$326.28
	Total	$582.28	$326.28

Requestor's Position

"The patient is entitled to reasonable medical care as stipulated in Texas law as related to the original injury. They do not require precertification/preauthorization."

Amount in Dispute: $582.28

Respondent's Position

"Enclosed please find a copy of the EOBs which set forth the denial of each date of service."

Response Submitted by: Downs Stanford, P.C.

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 §134.220, set out the medical fee guidelines for case management services
4. 28 TAC §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
5. 28 TAC §134.600 sets out the guidelines for preauthorization, concurrent review, and retrospective review.

Denial Reasons

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

- 5264 - Payment is denied-service not authorized.
- 5085 - Payment is denied as the billed diagnosis is not allowed in this claim.
- 197 - Payment denied/reduced for absence of precertification/authorization.
- N569 - Not covered when performed for the reported diagnosis.
- 96 - Non-Covered Charge(s).

Issues

1. Are the insurance carrier's denial reason codes "96, 5085 and N569" supported?
2. Is the requestor entitled to reimbursement for CPT Code 99361-W1?
3. Does the documentation support the billing of CPT code 99213?
4. Is the Insurance Carrier's denial reason(s) supported for CPT Code 99080-73?
5. Is the Requestor entitled to reimbursement?

Findings

1. The requestor is seeking reimbursement in the amount of $582.28, for CPT Codes 99361-W1, 99213 and 99080-73 rendered on March 15, 2021 through May 27, 2021. The respondent denied reimbursement for CPT code 99361-W1 based upon "96, 5085 and N569" (description provided above).

   28 TAC §133.307(d)(2)(H) requires the respondent to submit documentation "If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier must attach any related Plain Language Notice in accordance with §124.2 of this title (concerning Insurance Carrier Reporting and Notification Requirements)."

   The respondent did not submit a Plain Language Notice in accordance with §124.2 in accordance with 28 TAC §133.307(d)(2)(H) to support denial based upon "96, 5085 and N569."

The DWC finds the respondent did not support the "96, 5085 and N569" denial.

2. The requestor seeks reimbursement in the amount of $226.00 for CPT Code 99361-W1 rendered on March 15, 2021 and April 15, 2021. The insurance carrier denied the disputed service with denial reduction codes 197 and 5264 (description provided above).

   The DWC finds that the insurance carrier's denial reason for lack of preauthorization is not support per 28 TAC §134.600. As a result, the services in dispute are reviewed pursuant to 28 TAC §134.220.

   The fee guidelines for disputed services is found at 28 TAC §134.220.

   28 TAC §134.220(1) states, "Case management responsibilities by the treating doctor are as follows: (1) Team conferences and telephone calls shall include coordination with an interdisciplinary team. (A) Team members shall not be employees of the treating doctor. (B) Team conferences and telephone calls must be outside of an interdisciplinary program. Documentation shall include the purpose and outcome of conferences and telephone calls, and the name and specialty of each individual attending the team conference or engaged in a phone call."

   The submitted "Team Conference" report does not document the purpose and outcome of the conference; it does not specify that the team members are not employees of the treating doctor; and that the conference was not part of an interdisciplinary program. The DWC finds the requestor did not comply with the requirements outlined in 28 TAC §134.220(1).

   28 TAC §134.220(2) states, "Case management responsibilities by the treating doctor are as follows: (2) Team conferences and telephone calls should be triggered by a documented change in the condition of the injured employee and performed for the purpose of coordination of medical treatment and/or return to work for the injured employee."

   The submitted "Team Conference" report does not document a change in the injured employee's condition or that it was performed for the purpose of coordination medical treatment and/or returning the injured employee to work. The DWC finds the requestor did not comply with the requirements outlined in 28 TAC §134.220(2).

   28 TAC §134.220(4) states, "Case management responsibilities by the treating doctor are as follows: (4) Case management services require the treating doctor to submit documentation that identifies any health care provider that contributes to the case management activity. Case management services shall be billed and reimbursed as follows: (A) CPT code 99361. (i) Reimbursement to the treating doctor shall be $113. Modifier "W1" shall be added."

   The requestor billed $113.00 for CPT code 99361-W1 in accordance with 28 TAC §134.220(4). Based upon the above findings the DWC finds the respondent's denial of payment for CPT code 99361-W1 is supported because the "Team Conference" report does not meet documentation requirements found in 28 TAC §134.220(1) and (2).

3. The requestor seeks reimbursement for CPT Code 99213, in the amount of $326.28 rendered on April 8, 2021 and May 27, 2021. The insurance carrier denied the disputed service with denial reduction codes 197 and 5264 (description provided above).

   The DWC finds that the insurance carrier's denial reason for lack of preauthorization is not support per 28 TAC §134.600. As a result, the services in dispute are reviewed pursuant to 28 TAC §134.203.

   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."

   CPT code 99213 is described as, "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family."

   The division finds the submitted report supports billing code 99213; therefore, reimbursement is recommended per the fee guideline.

   28 TAC §134.203(c)(1) states "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."

   28 TAC §134.203(c)(2) states "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 DWC conversion factor for 2021 is 61.17.
   - The Medicare conversion factor for 2021 is 34.8931.
   - Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 75043 which is located in Garland, Texas; therefore, the Medicare locality is "Dallas."
   - The Medicare participating amount for CPT code 99213 at this locality is $93.06. Using the above formula, the MAR is $163.14. The respondent paid $0.00. The difference between MAR and amount paid is $163.14 x 2 units = total MAR $326.28; this amount is recommended for reimbursement.

4. The requestor seeks reimbursement in the amount of $30.00 for CPT Code 99080-73 rendered on April 8, 2021 and May 27, 2021. The insurance carrier denied the disputed service with denial reduction codes 197 and 5264 (description provided above).

   The DWC finds that the insurance carrier's denial reason for lack of preauthorization is not support per 28 TAC §134.600. As a result, the services in dispute are reviewed pursuant to 28 TAC §129.5.

   CPT Code 99080-73 CPT code 99080-73 is defined as "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form."

   28 TAC §134.239 states, "When billing for a work status report that is not conducted as a part of the examinations outlined in §134.240 and §134.250 of this title, refer to §129.5 of this title."

   28 TAC §129.5(i)(1) states "Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15. A doctor shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section."

   28 TAC §129.5 (d)(1) and (2) states "The doctor shall file the Work Status Report: (1) after the initial examination of the employee, regardless of the employee's work status; (2) when the employee experiences a change in work status or a substantial change in activity restrictions."

   A review of the submitted work status report finds insufficient documentation to the documentation of CPT Code 99080-73 as required per 28 TAC 129.5 (d)(1) and (2). The DWC finds the requestor did not support the billing of CPT code 99080-73 rendered on April 8, 2021 and May 27, 2021 in accordance with 28 TAC §129.5 (d)(2). As a result, reimbursement is not recommended.

5. The DWC finds that the requestor is entitled to reimbursement for CPT Code 99213 rendered on April 8, 2021 and May 27, 2021 in the amount of $326.28.

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 $326.28 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 $326.28 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		February 17, 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.