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

General Information

Requester Name
MEHREEN NADEEM

Respondent Name
HARTFORD UNDERWRITERS' INSURANCE CO

MFDR Tracking Number
M4-22-0926-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
January 19, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 16, 2021	99213	$163.14	$163.14
July 16, 2021	99080 -73	$15.00	$0.00
August 12, 2021	99361-W1	$113.00	$0.00
	Total	$291.14	$163.14

Requester's Position

"Dr. Nadeem was approved as treating doctor as of 6/15/2021. I have attached the DWC53 fur your reference. I have also attached a previous date of service that was paid on fur this patient. These claims should be PAID IN FULL to prevent JRO (Independent Review Organization) and MFDR (Medical Fee Dispute Resolution}. I have attached all necessary documentation."
Amount in Dispute: $291.14

Respondent's Position

"Bills were received, and both denied as not approved per the adjuster. Adjuster states: I told the doctor everything requires pre auth based on a peer review and they kept seeing her without auth."
Response Submitted by: The Hartford

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 §134.204 sets out the reimbursement guidelines for workers compensation specific services.
4. 28 TAC §129.5 effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
5. 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:

- 96 – Non covered charge(s).
- APPR – Reimbursement is being withheld as the treating doctor and/or services rendered were not approved based upon handler review.

Issues

1. Who is the treating doctor on record?
2. Is the requestor entitled to reimbursement for CPT Code 99361-W1?
3. Is the requestor entitled to reimbursement for CPT Code 99080-73?
4. Is the requestor entitled to reimbursement for CPT Code 99213?
5. Is the requestor entitled to reimbursement for the services in dispute?

Findings

1. The requestor seeks reimbursement of $291.14 for services rendered on July 16, 2021 and August 12, 2021. The insurance carrier reduced the payment amount with reduction codes 96 and APPR (descriptions provided above.)

   The insurance carrier states, "Adjuster states: I told the doctor everything requires pre auth based on a peer review and they kept seeing her without auth."

   The DWC finds that the insurance carrier did not deny the services in dispute due to lack of preauthorization, however denied as not treating doctor approved services.

   Review of the Commissioner's Order dated June 15, 2021 documents that the change of treating doctor from Mario G. Gonzalez to Dr. Mehreen Nadeem was approved by the Commission on June 15, 2021. The services were rendered by Dr. Mehreen Nadeem on July 16, 2021 and August 12, 2021 after the approval by the Commission, as a result, the insurance carrier denial reason is not supported, and the disputed services are reviewed pursuant to the DWC rules and guidelines.

2. The requestor seeks reimbursement for CPT Code 99361-W1 rendered August 12, 2021.

   Per 28 TAC §134.204(e)(2) states: "Case Management Responsibilities by the Treating Doctor is as follows: 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."

   28 TAC §134.204(e)(4) states "Case management services require the treating doctor to submit documentation that identifies any HCP 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 CPT code 99361-W1; however, the documentation does not support that the treating doctor participated in the case management service. Review of the TEAM CONFERENCE report finds that the requestor listed the participants in the conference; however, the record does not support the treating doctor participated to support billing code 99361- W1 in accordance with 28 TAC §134.204(e)(4)(A)(i). The documentation also does not support that the case management services were 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. As a result, reimbursement is not recommended.

3. The requestor seeks reimbursement for CPT Code 99080-73 rendered on July 16, 2021.

   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 §134.204 (l) states "The following shall apply to Work Status Reports. When billing for a Work Status Report that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section, refer to §129.5 of this title (relating to Work Status Reports)."

   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." The respondent submitted a copy of the report that does not indicate a change in claimant's work status in accordance with 28 Texas Administrative Code §129.5 (d)(1) and (2); therefore, reimbursement cannot be recommended.

4. Review of the submitted medical records, document, "Due to the Covid-19, this is a scheduled Tele-Visit." The requestor documented the office visit dated July 16, 2021 as a telemedicine visit.

   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."

   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. The DWC reviewed the Medicare Covered Telehealth services at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes, and found that the following:

   - CPT Code 99213 is a covered telehealth service. The requestor is therefore entitled 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
07/16/21	99213	1	$0.00	$163.14	$163.14 - $0.00 = $63.14	$163.14	$163.14
TOTAL			$0.00	$163.14	$163.14	$163.14	$163.14

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 $163.14.

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 additional reimbursement of $163.14 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to additional reimbursement for the disputed services. It is ordered that the Respondent must remit to Requester $163.14 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		February 11, 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 512-804-4812.