TDI Division of Workers' Compensation

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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Peak Integrated Healthcare

Respondent Name
Indemnity Insurance Co. of North America

MFDR Tracking Number
M4-22-1375-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
March 8, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 1, 2021	CPT Code 99213	$163.14	$163.14
	CPT Code 99080-73	$15.00	$15.00
	Total	$178.14	$178.14

Requestor's Position

"Evaluation and management outpatient visits to the offices of medical doctors play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The current TDI statutes and regulations require an injured worker to be present to sign a DWC work status form 73. The treating physician must meet with the injured worker in an office setting to access and determine the worker's status and complete the required form 73."

Amount in Dispute: $178.14

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, PC

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 §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.600 requires preauthorization for specific services listed in this rule.
3. 28 TAC §134.203 sets out the reimbursement guidelines for professional services.
4. 28 TAC §129.5 sets out the procedure for reporting and billing work status reports.

Denial Reasons

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

- Payment is denied-service not authorized.
- 197-Payment denied/reduced for absence of precertification/authorization.
- 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.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is Indemnity Insurance Co. of North America's denial based on a lack of preauthorization supported?
2. Is Peak Integrated Healthcare entitled to reimbursement for CPT code 99213?
3. Is Peak Integrated Healthcare entitled to reimbursement for CPT code 99080-73?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $178.14 for CPT codes 99213 and 99080-73 rendered on July 1, 2021.

   The respondent contends reimbursement is not due because requestor failed to obtain preauthorization.

   A review of 28 TAC §134.600(p) lists the non-emergency healthcare that requires preauthorization. The list does not identify office visits and work status reports; therefore, the respondent's denial based upon a lack of preauthorization is not supported.

2. 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 a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter."

   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. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   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, Texas."
   - The carrier code for Texas is 4412 and the locality code for Dallas is 11.
   - 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.

3. CPT code 99080-73 is described 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 documentations finds the requestor submitted a copy of the DWC-73 report to support billing. As a result, reimbursement of $15.00 is recommended.

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 $178.14 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. It is ordered that Indemnity Insurance Co. of North America must remit to Peak Integrated Healthcare $178.14 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		04/13/2022
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.