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

General Information

Requestor Name
JAMES A. MITCHELL, DC

Respondent Name
EMPLOYERS PREFERRED INSURANCE CO.

MFDR Tracking Number
M4-22-1867-01

Carrier's Austin Representative
Box Number 04

DWC Date Received
April 28, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 5, 2021 through August 3, 2021	99361-W1 x 3, 99213 x 2 and 99080-73 x 2	$695.28	$356.28
	Total	$695.28	$356.28

Requestor's Position

"AFTER SENDING THIS INFORMATION TO THEM NOW TWICE, WE ARE BEING DENIED PAYMENT BASED ON DUPLICATE. THIS IS INCORRECT AND WE ASK THAT YOU KINDLY ADJUDICATE."

Amount in Dispute: $695.28

Respondent's Position

The Austin carrier representative for Employers Preferred Insurance Company is Law Office of Ricky D. Green. Law Office of Ricky D. Green was notified of this medical fee dispute On May 3, 2022. 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 §134.204 sets out medical fee guidelines for workers' compensation specific services.
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 reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 247 – A payment or denial has already been recommended for this service.
- 18 – Exact duplicate claim/service.
- 5280 & 2005 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Did the requestor waive the right to dispute resolution for date of service April 5, 2021?
2. Is the Insurance Carrier's denial reason(s) supported for CPT Code 99361-W1?
3. Is the requestor entitled to reimbursement for CPT Code 99213?
4. Is the requestor entitled to reimbursement for CPT Code 99080-73?
5. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for medical services rendered on April 5, 2021. 28 TAC §133.307(c) (1) states in pertinent part, "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute."

   The date of the service in dispute is April 5, 2021. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on April 28, 2022. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in 28 TAC §133.307(c) (1) (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for date of service April 5, 2021.

2. The insurance carrier denied reimbursement for the case management services, billed under CPT Code 99361-W1, rendered on May 7, 2021 and June 8, 2021, based upon reason codes 2005, 5280, 16 and 247. Review of the documentation finds that the insurance carrier's denial reasons are not supported. The disputed services are therefore reviewed pursuant to 28 TAC §134.204 (e)(2).

   CPT Code 99361 is defined as "Case Management Services."

   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 submitted 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 99213 rendered on June 28, 2021 and August 3, 2021. The insurance carrier denied the disputed services with denial reduction codes 18, 247. Review of the documentation finds that the insurance carrier's denial reasons are not supported.

   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."

   CPT code 99213 is defined 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 physicians, other qualified health care professionals, 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. Typically, 15 minutes are spent face-to-face with the patient and/or family."

Review of the office visit notes supports the documentation and billing of CPT Code 99213. As a result, the requestor is entitled to reimbursement for the services in dispute.

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 disputed services were rendered in 2021.
- 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 zip code 75043; therefore, the Medicare locality is "Dallas, Texas."
- The Medicare Participating amount for CPT code 99213 at this locality is $93.06.
- Using the above formula, the DWC finds the MAR is $163.14.
- The respondent paid $0.00.
- Reimbursement of $163.14 is recommended for dates of service June 28, 2021 and August 3, 2021.
- The total recommended amount is $326.28.

4. The requestor seeks reimbursement for CPT Code 99080-73 rendered on June 28, 2021 and August 3, 2021. The insurance carrier denied the disputed services with denial reason codes 18, 247. Review of the documentation finds that the insurance carrier's denial reasons are not supported.

   CPT Code 99080-73 CPT 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."

The DWC finds the requestor supported the billing of CPT code 99080-73 in accordance with 28 TAC §129.5 (d)(2). As a result, reimbursement of $15.00 is recommended for dates of service June 28, 2021 and August 3, 2021 for a total recommended amount of $30.00.

5. The DWC finds that the requestor is entitled to reimbursement in the amount of $356.28, therefore this amount 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.

The DWC finds the requester has established that reimbursement of $356.28 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 $356.28 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 27, 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.