



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

PEAK INTEGRATED HEALTHCARE

Respondent Name

CITY OF RICHARDSON

MFDR Tracking Number

M4-22-1896-01

Carrier's Austin Representative

Box Number 44

DWC Date Received

May 3, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 24, 2021	99213 and 99080-73	\$178.14	\$178.14
	Total	\$178.14	\$178.14

Requestor's Position

"TDI provides that adjusters cannot make medical necessity decisions as it is a violation of their license issued by the Texas Department of Insurance. It is suggested by TDI rules to file a complaint of any carrier/adjuster that violates these protocols. Also, the amount billed is allowable for an 99213-office visit and DWC-73 report, We believe these bills should be paid."

Amount in Dispute: \$178.14

Respondent's Position

"If MDR were to issue Findings and Decision in this matter, rather than dismissing the Request, Respondent requests that the Division order reimbursement in the amount of \$0.00. Treatment for [injury] is unrelated to the compensable injury, and no reimbursement is warranted."

Response Submitted by: White Espey PLLC

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 §133.240 sets out the requirements for submission of a medical bill.
4. 28 TAC §133.305 sets out the procedures for resolving medical disputes.
5. 28 TAC §137.100 defines the treatment guidelines adopted by the Division of Workers' Compensation.
6. 28 TAC §19.2005 sets out the general standards of utilization review.

Denial Reasons

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

- T216 – Based on the findings of a review organization. Peer Review or RME.
- P12 – The charge for the procedure exceeds the amount indicated in the fee schedule.
- W3 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Does an unresolved extent of injury issue exist for this dispute?
2. Did the insurance carrier appropriately raise medical necessity for this dispute?
3. What is the definition of CPT Code 99213 and 99080-73?
4. Is the Requestor entitled to reimbursement for CPT Code 99213?
5. Is the Requestor entitled to reimbursement for CPT Code 99080-73?

Findings

1. The requestor seeks reimbursement for CPT Codes 99080-73 and 99213, rendered on August 24, 2021.

The insurance carrier states, "Respondent paid \$0 to Requestor as the treatment was not related to the compensable injury per the attached peer review."

28 TAC §133.305(b) states that if a dispute over the extent of a covered work injury exists for the same service for which there is a medical fee dispute, the dispute regarding the extent of injury shall be resolved prior to the submission of a medical fee dispute.

28 TAC §133.307 (d)(2)(H) states, "Responses to a request for MFDR must be legible and submitted to the division and to the requestor in the form and manner prescribed by the division... (2) Response. On receipt of the request, the respondent must provide any missing information not provided by the requestor and known to the respondent. The respondent must also provide the following information and records... (H) 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)."

Review of the documentation submitted by the parties finds that the carrier did not provide documentation to the DWC to support that it filed a Plain Language Notice (PLN) regarding the disputed conditions as required by 28 TAC §133.307(d)(2)(H) and the respondent did not submit information sufficient to support that the PLN had ever been presented to the requestor or that the requestor had otherwise been informed of PLN prior to the date that the request for medical fee dispute resolution was filed with the DWC; therefore, the division finds that the extent of injury denial was not timely presented to the requestor in the manner required by 28 TAC §133.240. Because the service in dispute does not contain an unresolved extent of injury issue, this matter is eligible for adjudication of a medical fee under 28 TAC §133.307. For that reason, this matter is addressed pursuant to the applicable rules and guidelines.

2. The insurance carrier denied the services in dispute with denial code "T216 – Based on the findings of a review organization. Peer Review or RME."

The insurance carrier states, "Per the peer review by Dr. Nakul Mahajan (see attached Exhibit 4), the treatment provided by Requestor on August 24, 2021 is not related to the injury."

28 TAC §133.307) states, "Responses to a request for MFDR must be legible and submitted to the division and to the requestor in the form and manner prescribed by the division... (2) Response. On receipt of the request, the respondent must provide any missing information not provided by the requestor and known to the respondent. The respondent must also provide the following information and records... (I) If the medical fee dispute involves medical necessity issues, the insurance carrier must attach documentation that supports an adverse determination in accordance with §19.2005 of this title (concerning General Standards of Utilization Review).

The insurance carrier refers to a peer review, however a copy of the peer review was not submitted with the DWC060 response. The DWC finds that the denial T216 was therefore not supported and the services in dispute are reviewed pursuant to 28 TAC §134.203.

3. 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 "Established patient office or other outpatient visit, 20-29 minutes."

CPT Code 99080-73 is defined as, "Work Status Report."

4. The reimbursement guideline for CPT Code 99213 is found in 28 TAC §134.203.

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 service was 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 75043, TX; therefore, the Medicare locality is "Dallas Texas."
- The Medicare Participating amount for CPT code(s) 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.

4. The reimbursement guidelines for CPT Code 99080-73 is found in 28 TAC §129.5.

28 TAC §129.5 (j) states, "Notwithstanding any other provision of this title, a doctor, delegated physician assistant, or delegated advanced practice registered nurse may bill for, and an insurance 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 insurance carrier, its agent, or the employer through its insurance carrier asks for an extra copy. The amount of reimbursement shall be \$15. A doctor, delegated physician assistant, or delegated advanced practice registered nurse 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, delegated physician assistants, or delegated advanced practice registered nurses are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors, delegated physician assistants, or delegated advanced practice registered nurses billing for Work Status Reports as permitted by this section shall do so as follows..."

The requestor is therefore entitled to reimbursement in the amount of \$15.00 for CPT Code 99080-73. Therefore, this amount is recommended.

5. The DWC finds that the requestor is entitled to a total recommended amount of \$178.14.

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 reimbursement of \$178.14 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 \$178.14 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____	_____	<u>June 16, 2022</u>
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 electrónico CompConnection@tdi.texas.gov.