



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

CENTER FOR PAIN RELIEF

**Respondent Name**

HARTFORD CASUALTY INSURANCE CO.

**MFDR Tracking Number**

M4-22-2361-01

**Carrier's Austin Representative**

Box Number 47

**DWC Date Received**

July 5, 2022

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 23, 2022	99442	\$163.47	\$163.47
<b>Total</b>		\$163.47	\$163.47

### Requestor's Position

"The carrier denied payment stating, 'services not documented in patient's medical record.' We included the documentation for our service with our original claim. We sent a reconsideration to the carrier with another copy of the documentation for the service provided. The carrier denied payment again, stating services not documented in the patient's medical record."

**Amount in Dispute:** \$163.47

### Respondent's Position

The Austin carrier representative for Hartford Casualty Insurance Company is Burns Anderson Jury Brenner. Burns Anderson Jury Brenner was notified of this medical fee dispute on July 12, 2022. 28 TAC §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 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.

### Denial Reasons

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

- 90201-SERVICES NOT DOCUMENTIED IN PATIENTS' MEDICAL RECORDS.
- P12-WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 309-THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
- 5405-THIS CHARGE WAS REVIEWED THROUH THE CLINICAL VALIDATION PROGRAM.
- 5721-TO AVOID DUPLICATE BILL DENIAL FOR ALL RECONSIDERATIONS/ADJUSTMENTS/ ADDITIONAL PAYMENT REQUESTS SUBMIT A COPY OF THIS EOR OR CLEAR NOTATION.

### Issues

1. Is the Insurance Carrier's denial reason(s) supported?
2. Is the Requestor entitled to reimbursement?

### Findings

1. The requestor seeks reimbursement in the amount of \$163.47 for CPT Code 99442, rendered on March 23, 2022. The insurance carrier denied the disputed service with denial reduction codes indicated above.

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 99442 is defined as "Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next **24** hours or soonest available appointment; **11-20** minutes of medical discussion."

Review of the documentation supports the documentation and billing of CPT Code 99442. As a result, the insurance carrier's denial reasons are not supported. Reimbursement is therefore recommended.

2. 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).

- Date of service was rendered in 2022
- The 2022 DWC Conversion Factor is 62.46
- The 2022 Medicare Conversion Factor is 34.6062
- Per the medical bills, the services were rendered in zip code 75039; therefore, the Medicare locality is "Dallas."
- The Medicare Participating amount for CPT code 99442 at this locality is \$92.46.
- Using the above formula, the DWC finds the MAR is \$166.88.
- The respondent paid \$0.00.
- The requestor seeks \$163.47 applicable 28 TAC 134.203(h) states that the total reimbursement is the lesser of the maximum allowable reimbursement (MAR) and the billed amount, as a result the requestor is entitled to \$163.47.
- Reimbursement of \$163.47 is recommended.

The DWC finds that the requestor is entitled to reimbursement in the amount of \$163.47. 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 requestor has established that additional reimbursement of \$163.47 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 service. It is ordered that the Respondent must remit to the Requestor \$163.47 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

### Authorized Signature

_____	_____	<u>October 20, 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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).