

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

PEAK INTEGRATED HEALTHCARE

Respondent Name

SOMPO AMERICA FIRE & MARINE INSURANCE

MFDR Tracking Number

M4-22-2456-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

July 21, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 26, 2022	99214	\$236.35	\$236.35
	Total	\$236.35	\$236.35

Requestor's Position

"The date of service was denied full payment. This is INCORRECT. There was a comprehensive examination that involved extensive orthopedic testing , motor function/muscle testing of CERVICAL, HIP , LUMBAR. AND SHOULDER . There was also a COMPREHENSIVE history taken of injuries and symptoms. Finally, there was a plan made with other health care professionals for future treatment. See definition of CPT CODE 99204 below."

Amount in Dispute: \$236.35

Respondent's Position

"The EOB denied reimbursement for CPT code 99214 on the basis of the information submitted with the medical bill did not support that level of service. Plus, the service was denied as the level of E&M (evaluation and management change) code submitted was not supported by documentation. The carrier maintains its position as identified in its EOB dated May 26, 2022. The provider is not entitled to any reimbursement for CPI code 99214."

Response Submitted by: Flahive, Ogden & Latson

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:

- 5405 – THIS CHARGE WAS REVIEWED THROUGH THE CLINICAL VALIDATION PROGRAM
- 5721 - TO AVOID DUPLICATE BILL DENIAL RECONSIDERATIONS/ADJUSTMENTS/ ADDITIONAL PAYMENT REQUESTS SBBMIT A COPY OF THIS EOR OR CLEAR NOTATION.
- 6270 – AFTER REVIEW OF THE BILL AND THE MEDICAL RECORD THIS SERVICE: IS BEST DESCRIBED BY 99213. SUBMITTED DOCUMENTATION DID NOT MEET AT LEAST 2 OF 3
- 90166 - PAYMENT ADJUSTED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LFYEL OF SERVICE
- 5406 - This Charge Was Reviewed Through The Clinical Validation Program
- 5721 - To avoid duplicate bill denial for all reconsideration's/ adequate payment requests submit a copy of this EOR or clear notation that a recon...
- 6270 - After review of the bill and the medical record this service is best described by 99213. Submitted documentation did not meet at least 2 of the 2 docs.
- 150 -PAYMENT ADJUSTED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE.
- 5052 - CV· Service reduced/denied as level of E&M code submitted is not supported by documentation.

Issues

1. Are the Insurance Carrier's denial reasons supported?
2. Do the disputed services contain NCCI edit conflicts that may affect reimbursement?
3. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Codes 99214 rendered on April 26, 2022. The insurance carrier denied reimbursement based on documentation does not support the level of service.

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 99214 is described 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: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or 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 moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family."

A review of the submitted medical report supports the billing code 99214; therefore, reimbursement is 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).

- 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 75006; therefore, the Medicare locality is "Dallas, Texas."
 - The Medicare Participating amount for CPT code 99214 at this locality is \$130.96.
 - Using the above formula, the DWC finds the MAR is \$236.37.
 - The respondent paid \$0.00.
 - The requestor seeks \$236.35, 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 \$236.35.
3. The DWC finds that the requestor is entitled to reimbursement in the amount of \$236.35, 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 reimbursement of \$236.35 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 \$236.35 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____	_____	<u>August 10, 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.