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
STONINGTON INSURANCE COMPANY

MFDR Tracking Number
M4-22-2646-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
August 19, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 17, 2022 through June 29, 2022	99213, 99080-73 x 3 and 99361-W1	$352.22	$182.22
	Total	$352.22	$182.22

Requestor's Position

"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. In order to satisfy the TDI requirements, an office visit is billed for the required time taken by the treating physician to assess the injured worker's return to work status."

Amount in Dispute: $352.22

Respondent's Position

"In fact, they all appear to be duplicates except for the dates. The work restrictions are the same for all three. The provider is not entitled to any reimbursement for those work status reports. Procedure codes 99361 and 99362 used for case conference/team conference are now invalid.

Additionally, the carrier maintains its position with respect to CPT codes 99213 and 99361-Wl. The provider is not entitled to any additional reimbursement."

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.
3. 28 TAC §129.5 sets out the fee guidelines for the DWC73 reports.
4. 28 TAC §134.220 sets out the requirements for case management.

Denial Reasons

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

- 190 - BILLING FOR REPORT AND/OR RECORD REVIEW EXCEEDS REASONABLENESS.
- P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- N600 – ADJUSTED BASED ON THE APPLICABLE FEE SCHEDULE FOR THE REGION IN WHICH THE SERVICE WAS RENDERED.
- 247 - A PAYMENT OR DENIAL HAS ALREADY BEEN RECOMMDNED FOR THIS SERVICE.
- 18 - EXACT DUPLICATE CLAIM/SERVICE.
- 197 - PAYMENT IS DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/ AUTHORIZATION.
- 5254 - PAYMENT IS DENIED SERVICE NOT AUTHORIZED.

Issues

1. What rules apply to the disputed services?
2. Is the requestor entitled to reimbursement for CPT Code 99080-73?
3. Is the requestor entitled to reimbursement for CPT Code 99213?
4. Is the requestor entitled to reimbursement for CPT Code 99361-W1?
5. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Codes 99213 X 1, 99080-73 X 3 and 99361-W1 rendered on May 17, 2022 through June 29, 2022.

   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."

The requestor billed CPT Code 99213 on June 14, 2022.

- CPT Code 99213 is defined 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 DWC finds that 28 TAC §134.203 applies to the reimbursement of CPT Code 99213.

The requestor billed CPT Code 99080-73 rendered on May 17, 2022, May 31, 2022, and June 14, 2022.

- 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."

The DWC finds that 28 TAC §129.5 applies to the reimbursement of CPT Code 99080-73.

The requestor billed CPT Code 99361-W1 rendered on June 29, 2022.

- CPT Code 99361-W1 is defined as "Case management."
- Modifier W1 is defined as "Reimbursement to the treating doctor."

28 TAC 134.220 (2), states "Team conference and telephone calls should be triggered by a documented change in the condition of the injured employee. Review of the submitted document, 'Team Conference' found insufficient information to support any change in the condition prompting the need of a team conference."

The DWC finds that 28 TAC 134.220 applies to the reimbursement of CPT Code 99361-W1.

2. CPT Code 99080-73 rendered on May 17, 2022, May 31, 2022 and June 14, 2022 were denied with denial reasons indicated above.

   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 documentation finds the following:

Review of the DWC 73 rendered on May 17, 2022 finds that the requestor met the documentation requirements outlined in 28 TAC §129.5, therefore, reimbursement of $15.00 is recommended for this report.

Review of the DWC 73 rendered on May 31, 2022, the requestor did not document a change in work status or a substantial change in activity restrictions, as a result, the requestor is not entitled to reimbursement for this report.

Review of the DWC 73 rendered on June 29, 2022, the requestor did not document a change in work status or a substantial change in activity restrictions, as a result, the requestor is not entitled to reimbursement for this report.

The DWC finds that the requestor met the documentation requirements for the DWC-73 rendered on May 17, 2022 and therefore the requestor is entitled to reimbursement in the amount of $15.00 for this date of service.

3. CPT Code 99213 rendered on June 14, 2022 was denied with denial reasons 5254 and 197, description provided above.

   28 TAC §134.600(p)(12) states in pertinent part "(p) Non-emergency health care requiring preauthorization includes: (12) treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits)."

   Review of the Division of Workers' Compensation Disability Management Questions and Answers document updated on 06/26/2014 states the following, "When do office visits require preauthorization? Office visits do not require preauthorization but are subject to retrospective utilization review of medical necessity. Although the ODG recommends office visits in the procedure summaries, there is not an established cap to limit medically necessary office visits."

   The DWC finds that the insurance carrier's denial reason of "197"and "5254" is not supported. As a result, the requestor is entitled to reimbursement for the office visit rendered on June 14, 2022.

   A review of the medical documentation for the office visit finds that the requestor documented and billed CPT Code 99213 as a result, the requestor is entitled to reimbursement.

   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).

Dates of service 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 75043; the Medicare locality is "Dallas."
- The Medicare Participating amount for CPT code 99213 at this locality is $92.65.
- Using the above formula, the DWC finds the MAR is $167.22.
- The respondent paid $0.00.
- The requestor is due $167.22 is recommended.

4. CPT Code 99361-W1 was denied with denial reason codes indicated above.

   DWC Rule 28 TAC §134.220 (2) states in pertinent part, 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.

   Review of the submitted document titled "Team Conference" does not indicate a change in the condition of the injured employee. Payment cannot be recommended.

5. The DWC finds that the requestor is entitled to reimbursement in the amount of $182.22. 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 $182.22 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 $182.22 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 27, 2022 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.