TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision
General Information

Requestor Name
PEAK INTEGRATED HEALTHCARE

Respondent Name
ACE AMERICAN INSURANCE COMPANY

MFDR Tracking Number
M4-23-0468-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
October 19, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 21, 2021	99213, 99080-73 and 99361-W1	$291.14	$178.14
	Total	$291.14	$ 178.14

Requestor's Position

"The above date of service was denied full payment stating, 'BASED ON FINDINGS OF A REVIEW ORGANIZATION.'...The patient is entitled to reasonable medical care as stipulated in Texas law as related to the original injury. Office visits are recommended as determined to be medically necessary...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: $291.14

Respondent's Position

"...before the Medical Review Division can make a determination on whether a service should be paid or not, there must first be a determination that the services are medically necessary. Once the provider received the EOB that denied services in part on the basis of lack of medical necessity, the provider should have filed a request for reconsideration and from there, if still in disagreement, he should have filed a request for an independent review organization (IRO)... If he has not done so and until he does so successfully, he is not entitled to pursue medical fee dispute resolution."

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 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 §129.5 sets out the fee guidelines for the DWC73 reports.
4. 28 TAC §134.220 sets out the requirements for case management.
5. 28 TAC §19.2003 sets out the definitions for utilization review for health care provided under workers' compensation insurance coverage.
6. 28 TAC §137.100 sets out the treatment guidelines.

Denial Reasons

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

- W3 - BILL IS A RECONSIDERATION OR APPEAL.
- 216 - BASED ON THE FINDINGS OF A REVIEW ORGANIZATION.
- 2005 - NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF AFPEAL/ RECONSIDERATION.

Issues

1. Did the insurance carrier appropriately raise medical necessity?
2. What rules apply to the reimbursement of CPT Codes 99080-73, 99213 and 99361-W1?
3. Is the requestor entitled to reimbursement for CPT Code 99080-73?
4. Is the requestor entitled to reimbursement for CPT Code 99213?
5. Is the requestor entitled to reimbursement for CPT Code 99361-W1?
6. Is the Requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services as these are non-covered services because this is not deemed a medical necessity by the payer.

   DWC Rule 28 TAC §137.100 (e) states, "An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017."

Retrospective utilization review is defined in 28 TAC §19.2003 (b)(31) as, "A form of utilization review for health care services that have been provided to an injured employee. Retrospective utilization review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted."

Additionally, 28 TAC §133.240 (q) states, in relevant part, "When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title and when the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title…, including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor ..."

Submitted documentation does not support that the insurance carrier followed the appropriate procedures for a retrospective review denial of the disputed services outlined in §19.2003 (b)(31) or §133.240 (q). The DWC finds that the insurance carrier did not appropriately raise medical necessity for this dispute. As a result, the insurance carrier's denial reason is not supported and the disputed services are reviewed pursuant to the applicable rules and guidelines.

2. The requestor seeks reimbursement for CPT Codes 99213, 99080-73 and 99361-W1 rendered on December 21, 2021.

   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.

   - 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.

   - 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 for CPT Code 99361-W1.

- CPT Code 99361-W1 is defined as "Case management services."
- Modifier W1 indicates that the case management services were rendered by the treating doctor.

28 TAC 134.220 (2), states '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."

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

3. CPT Codes 99080-73 rendered on December 21, 2021 is reviewed pursuant to the applicable rules and guidelines.

   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:

   The DWC finds that the requestor met the documentation requirements for the DWC-73 rendered on December 21, 2021, and therefore the requestor is entitled to reimbursement in the amount of $15.00 for this date of service.

4. CPT Codes 99213 rendered on December 21, 2021 is reviewed pursuant to the applicable rules and guidelines.

   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 for CPT Code 99213.

   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 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 75211; the Medicare locality is "Dallas."
- 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.
- The requestor is due $163.14.

5. CPT Code 99361-W1 rendered on December 21, 2021 is reviewed pursuant to the applicable rules and guidelines.

   The 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. As a result, reimbursement cannot be recommended.

6. The DWC finds that the requestor is therefore entitled to a total reimbursement in the amount of $178.14. 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 $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

		January 9, 2023
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.