



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

CENTER FOR PAIN RELIEF

Respondent Name

TRAVELERS INDEMNITY COMPANY

MFDR Tracking Number

M4-23-0532-01

Carrier's Austin Representative

Box Number 05

DWC Date Received

October 28, 2022

Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|------------------|-------------------|-------------------|------------|
| April 6, 2022 | 99442 | \$45.50 | \$45.50 |
| Total | | \$45.50 | \$45.50 |

Requestor's Position

"The carrier issued incorrect allowable payment for Code 99442. We sent a reconsideration to the carrier notifying them of the incorrect payment and they stated the claim was processed correctly. The same code billed for this patient for a prior date of service and a later date of service were paid correctly. This date of service should be paid the same as the others."

Amount in Dispute: \$45.50

Respondent's Position

"The Provider contends they are entitled to additional reimbursement for the disputed service. The Carrier has reviewed the disputed billing and confirmed the Provider was reimbursed per the facility rate for the telehealth services. The two additional dates of service referenced by the Provider in support of their contention that additional dates of service referenced by the Provider in support of their contention that additional reimbursement is due were also reviewed. Those two dates were incorrectly reimbursed. The Carrier has reviewed the Maximum Allowable Reimbursement calculation and contends the reimbursement for this date of service is correct as calculated."

Response Submitted by: Travelers

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 §133.30 sets out the Telemedicine and Telehealth Services.

Denial Reasons

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

- P12 – Workers Compensation jurisdictional fee schedule adjustment.
- 790-31 – This charge was reimbursed in accordance with the Texas Medical Fee Guideline.

Issues

Is the insurance carrier's reduction of payment supported?

Findings

The requestor seeks an additional payment amount of \$45.50 for CPT Code 99442. The insurance carrier issued a payment in the amount of \$121.38 and reduced the remaining charge with reduction codes P12 and 790-31 (descriptions provided above).

Review of the submitted medical documentation documents that the service in dispute is a telemedicine visit. The DWC finds that the requestor documented the visit as a telemedicine visit.

Per 28 TAC §133.30 a health care provider may bill and be reimbursed for telemedicine and telehealth services regardless of the geographical area or location of the injured employee. Telehealth and telemedicine services are billed as professional services.

Reimbursement for professional services is established by the Medical Fee Guideline for Professional Services, 28 TAC §134.203.

28 TAC §134.203(b)(1) states in part "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."

28 TAC §134.203 (a)(7) states that specific Texas Labor Code provisions and division rules take precedence over conflicting CMS provisions administering Medicare. The division finds no provisions in the Labor Code or its adopted rules that conflict with the CMS Interim Final Rule 19230. As there are no conflicts, the maximum allowable reimbursement (MAR) for telemedicine services provided in the workers' compensation services follow Medicare payment policies. As Medicare reimburses telemedicine services under the non-facility rate per Interim Final Rule

19230, the division finds that the MAR for telemedicine services is calculated using the non-facility rate.

The DWC now considers whether the disputed services are covered telemedicine or telehealth services. Review of the Medicare Covered Telehealth services at <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>, found that the disputed services are CPT Codes listed in the covered telehealth code list. The disputed codes are therefore subject to reimbursement pursuant to 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 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 \$121.38.
- Additional reimbursement of \$45.50 is recommended.

The DWC finds that the requestor is entitled to an additional payment amount of \$45.50. 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 requester has established that additional reimbursement of \$45.50 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 \$45.50 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

January 9, 2023
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.