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
HARTFORD CASUALTY INSURANCE COMPANY

MFDR Tracking Number
M4-23-0883-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
December 15, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 4, 2022	99213 and 99080-73	$182.22	$182.22
	Total	$182.22	$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: $182.22

Respondent's Position

"The bill was reprocessed and denied as not authorized/not approved by adjuster on 1/4/23 under control number 901795383 per adjuster's response: Please deny bill as no prior authorization ,and outside of ODG guidelines. The peer review notes visits with Elite a chiropractor, monthly drug screens, and team conferences (as documented by Elite Healthcare) are not within the Guidelines."

Response Submitted by: Hartford

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.

Denial Reasons

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

- 193 – ORIGINAL PAYMENT DECISION IS BEING :MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 1115 – WE FIND THE ORIGINAL REVIEW TO BE ACCURATE AND ARE UNALBE TO RECOMMEND ADDITIONAL ALLOWANCE.
- 309 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
- P12 – WORKERS COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- CONT – WE ARE IN RECEIPT OF YOUR BILL FOR SERVICE PAYMENT IS BEING WITHELD PENDING FURTHER INVESTIGATION OF COMPENSABILITY OR TREATMENT.

Issues

1. Does the respondent's position statement address only the denial reasons presented to the requestor prior to the date the request for MFDR was filed?
2. Is the Insurance Carrier's denial of extent of injury supported?
3. What rules apply to the disputed services?
4. Is the requestor entitled to reimbursement for CPT Code 99080-73?
5. Is the requestor entitled to reimbursement for CPT Code 99213?
6. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Codes 99213 and 99080-73 rendered on October 4, 2022.

   The insurance carrier's position summary states, "Please deny bill as no prior ***authorization and*** outside of ODG guidelines."

   28 TAC §133.307(d)(2)(F) states "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

The respondent submitted copies of EOBs with a process date of January 4, 2023, this date is after the submission of the DWC060 request, by the requestor.

The DWC finds that the respondent submitted a position summary containing new denial reasons and defenses. The additional denial reasons identified on the position summary, are not denial reasons raised during the medical bill review process, as they are not indicated on the Explanation of Benefits presented with the DWC060 request.

The respondent submitted insufficient information to MFDR to support that the denial reasons raised in their position summary were presented to the requestor prior to the date that the request for medical fee dispute resolution was filed with the DWC; therefore, the DWC concludes that the respondent has waived the right to raise such additional denial reasons or defenses. Any new denial reasons or defenses raised after the filing of the MDR, shall not be considered in this review.

2. The service in dispute was denied by the workers' compensation carrier due to an unresolved extent of injury issue. 28 TAC §133.305 (b) states that if a dispute over the extent of a covered work injury exists for the same service for which there is a medical fee dispute, the dispute regarding the extent of injury shall be resolved prior to the submission of a medical fee dispute.

   Review of the documentation submitted by the parties finds that the carrier did not provided documentation to the Division to support that it filed a Plain Language Notice (PLN) regarding the disputed conditions as required by 28 TAC §133.307(d)(2)(H). The respondent did not submit information to MFDR, sufficient to support that the PLN had ever been presented to the requestor or that the requestor had otherwise been informed of PLN prior to the date that the request for medical fee dispute resolution was filed with the Division; therefore, the division finds that the extent of injury denial was not timely presented to the requestor in the manner required by 28 TAC §133.240. Because the service in dispute does not contain an unresolved extent of injury issue, this matter is ripe for adjudication of a medical fee under 28 TAC §133.307. For that reason, this matter is addressed pursuant to the applicable rules and guidelines.

3. 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.

4. CPT Codes 99080-73 rendered on October 4, 2022 was denied with the denial reasons indicated above. Review of the submitted documentation finds that the insurance carrier's denial reasons are not supported. As a result, the disputed CPT Code 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 and therefore, the requestor is entitled to reimbursement in the amount of $15.00 for this date of service October 4, 2022.

5. CPT Code 99213 rendered on October 4, 2022 was denied with the denial reasons indicated above. Review of the submitted documentation finds that the insurance carrier's denial reasons are not supported. The disputed service is therefore 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 for 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).

Date 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 service was rendered in zip code 75043; the Medicare locality is "Dallas Texas."
- The Medicare Participating amount for CPT 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 for date of service October 4, 2022.

6. The DWC finds that the requestor is entitled to a total 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

		February 27, 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.