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 INTGRATED HEALTHCARE

Respondent Name
HARTFORD CASUALTY INSURANCE COMPANY

MFDR Tracking Number
M4-23-1336-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
February 8, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 7, 2022	99213 and 99080-73	$182.22	$182.22
	Total	$182.22	$182.22

Requestor's Position

"The above date of service was denied payment a 'WORKERS COMPENSATION JURISDICTIONAL FEE ADJUSTMENT.' This is INCORRECT. Office visits are recommended as determined to be medically necessary. The patient is entitled to reasonable medical care as stipulated in Texas law as related to the original injury."

Amount in Dispute: $182.22

Respondent's Position

"Please accept this letter as a response to the above dispute, The bill in question was processed and denied as at Maximum Medical Improvement and not approved per the adjuster's instructions: Still denied. Pre-cert was not given. A Designated Doctor exam put the claimant at MMI on 8/13/19 (attached)."

Response Submitted by: The Hartford

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §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, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.
2. 28 TAC §180.22, requires the treating doctor to coordinate the claimant's health care.
3. TLC §408.021, titled, *Entitlement to Medical Benefits*.
4. TLC §408.022, titled, *Selection of Doctor*.
5. 28 TAC §126.9, sets out the guidelines for billing and reimbursement of work status reports.
6. 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:

- 96 – Non-Covered Charge(s).
- MMI – The opinion of the designated doctor is given presumptive weight regarding MMI and Impairment. Maximum medical improvement has been reached.
- NABA – Reimbursement is being withheld as the treating doctor and/or services rendered were not approved based upon handler review.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Is the insurance carrier's denial of MMI supported?
2. Is the insurance carrier's denial of NABA supported?
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?

Findings

1. The insurance carrier denied disputed services with denial reason code "MMI – The opinion of the designated doctor is given presumptive weight regarding MMI and impairment. Maximum medical improvement has been reached."

   Texas Labor Code (TLC) §408.021, states, "(a) An employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment. (b) Medical benefits are payable from the date of compensable injury. (c) Except in an emergency, all

health care must be approved or recommended by the employee's treating doctor. (d) An insurance carrier's liability for medical benefits may not be limited or terminated by agreement or settlement."

The DWC published two Advisories 98-06 and Advisory 2003-01, to address the issues when an injured employee obtains certification of MMI, the advisories state in pertinent part, "A certification of maximum medical improvement does not mean that medical treatment is no longer necessary. An injured employee remains entitled to reasonable and necessary medical treatment after the date of maximum medical improvement."

The DWC finds that the insurance carrier's denial reason is not supported. The disputed services are reviewed pursuant to the applicable rules and guidelines.

2. The insurance carrier denied the disputed service with denial reason "NABA-Reimbursement is being withheld as the treating doctor and/or services rendered were not approved based upon handler review."

   28 TAC §180.22(c)(1) states, "The treating doctor is the doctor primarily responsible for the efficient management of health care and for coordinating the health care for an injured employee's compensable injury. The treating doctor shall: (1) except in the case of an emergency, approve or recommend all health care reasonably required that is to be rendered to the injured employee including, but not limited to, treatment or evaluation provided through referrals to consulting and referral doctors or other health care providers, as defined in this section."

   28 TAC §126.9(f) states, "The commission shall issue an order approving or denying a change of doctor request. This order shall be issued within 10 days after receiving the request and, if a change is approved, shall include an order for the insurance carrier to pay for treatment provided by the approved doctor unless superseded by a subsequent order."

   Review of the commission order, dated May 10, 2019 finds that the request to change the treating doctor, was approved from Dr. Karen Dickerson to Dr. James Arthur Mitchell. The disputed date of service is September 7, 2022 and was rendered by Dr. Mitchell the approved treating doctor on record. The DWC therefore finds that the insurance carrier's denial reason is not supported. The requestor is therefore entitled to reimbursement for the disputed services.

3. CPT Codes 99080-73 rendered on September 7, 2022 were denied with 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 Codes are reviewed pursuant to the applicable rules and guidelines.

   28 TAC §129.5(j)(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 (e)(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 September 7, 2022, as a result, the requestor is due reimbursement in the amount of $15.00 for this date of service.

4. A review of the medical documentation for date of service September 7, 2022, 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).

   Service Date 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 75211; 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.

5. The DWC finds that the requestor has established that reimbursement is due. As a result, the requestor is entitled to $182.22.

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 in the amount of $182.22 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to reimbursement for the services in dispute. 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	May 15, 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 managing 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.