Division of Workers' Compensation

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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
PEAK INTEGRATED HEALTHCARE

Respondent Name
INDEMNITY INSURANCE COMPANY

MFDR Tracking Number
M4-23-2161-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
May 3, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 9, 2022 and January 11, 2023	99213 and 99361-W1	$287.71	$174.72
	Total	$287.71	$174.72

Requestor's Position

"The attached dates of service were denied payment unjustly, abence of certification/ authorization and 'billed diagnosis is not allowed in this claim.' This is INCORRECT as we have been billing for this work injury/diagnosis code and have received multiple payments, I have attached a PAYMENT for 12/06/2022 office that was paid."

Amount in Dispute: $287.71

Respondent's Position

"The services in dispute were denied as the services provided were not only for the compensable injury. Per the documentation, the Claimant was being treated for the following diagnoses: [diagnosis]. Per the PLN-11 filed on 2/22/2022, Respondent only accepted a [injury] as the compensable injury. Requestor was not treating a..., therefore, the denial based on extent of injury is appropriate. In conclusion, reimbursement is not owed to Requestor for treating non-compensable diagnoses."

Response Submitted by: Downs Stanford, P.C.

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) §133.305 sets out the procedures for resolving medical disputes.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 TAC §134.203 sets out the fee guideline for professional medical services.

Denial Reasons

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

- 5085 – Payment is denied as the billed diagnosis is not allowed in this claim.
- 5264 – Payment is denied-service not authorized.
- 5477 – Charges denied as claim is still under investigation.
- 197 – Payment denied/reduced for absence of precertification/authorization.
- 96 – Non-covered charge(s).
- P8 – Claim is under investigation.
- N589 – Not covered when performed for the reported diagnosis.
- 1014 – Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 561 – According to the state fee schedule, this procedure code is not considered a valid reimbursable code. Please re-submit with a valid code.
- 5628 – The date of service is not related to the above referenced claim. Please submit the bill to the patient or patients health care plan for payment.
- 109 – Claim ot covered by the payer/contractor. You must send the claim to the correct payer/contractor.
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3 – Billi s a reconsideration or appeal.
- N706 – Missing documentation.
- MA45 – Alert: the new information was considered but additional payment will not be issued.
- CO – The amount adjusted due to a contractual obligation between the provider and the payer. It is not the patient's responsibility under any circumstances.
- PI – These are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not 'reasonable or necessary.' The amount adjusted is generally not the patient's responsibility, unless the workers' compensation state law allows the patient to be billed.

Issues

1. Is the insurance carrier's denial of extent of injury supported?
2. Is the insurance carrier's denial reason of medical necessity supported?
3. What is the description of CPT Code 99213 and 99361-W1?
4. What are the insurance carrier's denial reasons?
5. What rule applies to the reimbursement of CPT Code 99213?
6. What rule applies to the reimbursement of CPT Code 99361-W1?
7. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Codes 99213 and 99361-W1 rendered on December 19, 2022 and January 11, 2023.

   The services in dispute were 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 compensability of a covered work injury exists for the same service for which there is a medical fee dispute, the dispute regarding the compensability shall be resolved prior to the submission of a medical fee dispute.

   Review of the documentation submitted, finds that the insurance carrier did not provided documentation to the DWC 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, to support that the PLN had ever been presented to the requestor or that the requestor had otherwise been informed of a PLN prior to the date that the request for medical fee dispute resolution was filed with the DWC; therefore, the DWC 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 services in dispute do not contain an unresolved compensability issue, this matter is eligible for review under 28 TAC §133.307. For that reason, this matter is addressed pursuant to the applicable rules and guidelines.

2. The insurance carrier denied the disputed services due to 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 3 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). Because the services in dispute do not contain an unresolved medical necessity issue, this matter is eligible for review under 28 TAC §133.307. For that reason, this matter is addressed pursuant to the applicable rules and guidelines.

3. The requestor seeks reimbursement for CPT Codes 99213 and 99361-W1 rendered on December 19, 2022 and January 11, 2023. The insurance carrier denied the disputed service with denial reduction codes indicated above.

   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.”

   CPT Code 99213 is described as, “CPT code 99213 is described 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.”

   CPT Code 99361 is described as case management services.

   Modifier -W1 is described as, reimbursement to the treating doctor.

4. The insurance carrier denied the disputed services with denial reduction codes, indicated above. Review of the submitted documentation does not contain sufficient documentation to support the insurance carrier’s denial reasons indicated above.

   The DWC finds that the insurance carrier’s denial reasons are not supported, as a result, the disputed services are reviewed pursuant to the applicable rules and guidelines.

5. The requestor seeks reimbursement for CPT Codes 99213, rendered on January 11, 2023.

   Per 28 TAC §134.203 sets out the guidelines for office visits.

   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... (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 2023 DWC Conversion Factor is 64.83.
- The 2023 Medicare Conversion Factor is 33.8872.
- Per the medical bills, the services were rendered in zip code 75211; therefore, the Medicare locality is "Dallas."
- The Medicare Participating amount for CPT code 99213 at this locality is $91.33.
- Using the above formula, the DWC finds the MAR is $174.72.
- The respondent paid $0.00.
- Reimbursement of $174.72 is recommended.

6. The requestor seeks reimbursement for CPT Code 99361-W1 rendered on December 19, 2022.

   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.

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

7. The DWC finds that due to the reasons indicated above, the requestor is entitled to a total reimbursement amount of $174.72. 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 $174.72 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, the DWC has determined the requestor is entitled to $174.72 reimbursement for the disputed services. It is ordered that the respondent must remit to the requestor the amount of $174.72, plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TC §134.120.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 14, 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 electronico CompConnection@tdi.texas.gov.