TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Lankford Hand Surgery Assn.

Respondent Name
Hartford Underwriters Insurance Co.

MFDR Tracking Number
M4-23-3148-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
August 14, 2023

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
06/22/2023	99212	$111.76	$109.58
06/22/2023	99080-73	$30.00	$15.00
06/22/2023	20550	$188.70	$0.00
	Total	$330.46	$124.58

Requestor's Position

"Pt has lifetime benefits, approved by adjustor for patient to come in. Please reprocess & pay. Also see approved injection approval attached."
Amount in Dispute: $330.46

Respondent's Position

"We reviewed the billing and supporting documentation received on the above claim and date of service and find that no additional allowance is due. The bill was processed and denied on 7/3/23 under control number … as MMI: Maximum Medical Improvement has been reached. Please see attached DWC069, and IME for MMI."
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 sets out the procedures for resolving medical fee disputes.
2. TLC 408.021 sets out the injured employees' entitlement to medical benefits.
3. TLC § 401.011(19) defines health care under Texas Workers' Compensation Act.
4. 28 TAC §134.203 sets out the fee guideline for professional medical services.
5. 28 TAC §129.5 sets out the fee guidelines for the DWC73 reports.

Denial Reasons

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

- MMI – The opinion of the designated doctor is given presumptive weight regarding MMI and impairment. Maximum medical improvement has been reached.
- 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 reason of the disputed services supported?
2. Is the requestor entitled to reimbursement for CPT Code 99212-25?
3. Is the requestor entitled to reimbursement for CPT Code 99080-73?
4. Is the requestor entitled to reimbursement for CPT code 20550-59-RT?

Findings

1. The insurance carrier denied all services rendered on June 22, 2023, stating that "Maximum medical improvement (MMI) has been reached."

   DWC finds that Texas Labor Code (TLC) 408.021 applies to the injured employee's entitlement to the disputed medical benefits, which states in pertinent part, "ENTITLEMENT TO MEDICAL BENEFITS. (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."

TLC 408.021 (b) states, "Medical benefits are payable from the date of the compensable injury."

TLC § 401.011(19) defines "Health Care" and states in part, ". . . includes all reasonable and necessary medical aid, medical examinations, medical treatment, medical diagnoses, medical evaluations, and medical services."

DWC finds that the injured employee involved in this dispute was entitled to the medical benefits rendered on the disputed date of service. Therefore, the insurance carrier's denial reason is not supported.

2. The requestor is seeking reimbursement in the amount of $111.76 for CPT code 99212-25 rendered on June 22, 2023.

   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 99212 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 straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter."
   - Per the medical bill submitted, the requestor billed CPT code 99212, and appended modifier -25. Modifier -25 indicates that on the day of a procedure, the patient's condition required a significant, separately identifiable E/M service, above and beyond the usual pre-and post-operative care associated with the procedure or service performed. Appropriate use of Modifier -25 includes when a minor procedure performed has a global period of "000" or "010" days listed on the Medicare physician fee schedule (MPFS).
   - The minor procedure / injection performed on the same date of service with CPT code 99212 was CPT code 20550, which has a global period "000" listed on the MPFS.
   - DWC finds that the requestor appropriately documented and appended modifier -25 to CPT code 99212. The requestor met the billing and reimbursement criteria for CPT code 99212-25; the insurance carrier's denial reason of "MMI has been reached" is not supported; therefore, the requestor is entitled to reimbursement of this evaluation and management code.

   DWC finds that 28 TAC §134.203 applies to the reimbursement of CPT code 99212-25 which states in pertinent part, "(c) To determine the maximum allowable reimbursement (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 = MAR.

- MPPR rates are published by carrier and locality.
- The disputed date of service is June 22, 2023.
- The disputed service was rendered in zip code 75246, locality 11, Dallas; carrier 4412.
- The Medicare participating amount for CPT code 99212 in 2023 at this locality is $57.28.
- The 2023 DWC Conversion Factor is 64.83
- The 2023 Medicare Conversion Factor is 33.8872
- Using the above formula, the DWC finds the MAR is $109.58.
- The requestor seeks $111.76.
- The respondent paid $0.00.
- Reimbursement in the amount of $109.58 is recommended.

DWC finds that the requestor is entitled to reimbursement in the amount of $109.58 for CPT code 99212-25 rendered on June 22, 2023.

3. The requestor is seeking reimbursement in the amount of $30.00 for CPT code 99080-73 rendered on June 22, 2023. CPT code 99080 is used to report and bill for a DWC specific Work Status Report.

   28 TAC §129.5(j)(1) which applies to the reimbursement of Work Status Reports states "…. 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 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."

   A review of the submitted documentation finds the following:

   DWC finds that the Work Status Report rendered on June 22, 2023, met the documentation requirements outlined in 28 TAC §129.5. It has been established above that the insurance carrier's denial reason based on "MMI has been reached" is not supported. Therefore, DWC finds that the requestor is entitled to reimbursement in the amount of $15.00 for CPT code 99080-73, Work Status Report, rendered on June 22, 2023.

4. The requestor is seeking reimbursement in the amount of $188.70 for CPT code 20550-59-RT rendered on June 22, 2023. CPT code 20550 is described as "injection(s); single tendon sheath, or ligament, aponeurosis…"

   As established above, 28 TAC §134.203(b)(1), applies to billing, reporting, and reimbursement of professional medical services and requires that Texas workers' compensation system participants adhere to Medicare payment policies, including its coding; billing; correct coding

initiatives (CCI) edits; modifiers…

Per CMS article A52863, Billing and Coding: Pain Management, documentation of the rendering of CPT code 20550 must include, "Required elements of the note include a description of the techniques employed, and sites(s) of injections, drugs and doses with volumes and concentrations as well as pre- and post-procedural pain assessments…" Regarding medical billing of CPT code 20550, the same article states in pertinent part, "The medication being injected, designated by an appropriate HCPCS drug code must be submitted on the same claim, same day of service as the claim for the procedure… A claim for services rendered in the office or independent clinic, when the physician does not bill for the injectables, must include the name of the drug and dosage in item 19 or the electronic equivalent."

Review of the medical record submitted finds no documentation describing the injection technique, nor the drug name and dosage injected. Review of the medical bill submitted finds no documentation of a drug name or dosage in item 19 of the bill.

DWC finds that the requestor did not meet the documentation and billing requirements for the reimbursement of CPT code 20550, therefore, the requestor is not entitled to reimbursement.

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 is due in the amount of $109.58 for CPT code 99212 and in the amount of $15.00 for CPT code 99080-73, both rendered on June 22, 2023.

Order

Under Texas Labor Code §§413.031 and 413.019, the division has determined the requester is entitled to reimbursement for some of the disputed services.

It is ordered that Hartford Underwriters Insurance Co. must remit to Lankford Hand Surgery Assn., $124.58 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		September 19, 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.