



Medical Fee Dispute Resolution Findings and Decision General Information

Requestor Name

David West, DO

Respondent Name

Service Lloyds Insurance Company

MFDR Tracking Number

M4-24-1200-01

Carrier's Austin Representative

Box Number 60

DWC Date Received

January 29, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 22, 2023	99205-95	\$433.11	\$0.00
Total		\$433.11	\$0.00

Requestor's Position

"DESIGNATED DR REFERRED TESTING NO PAYMENT RECEIVED."

Amount in Dispute: \$433.11

Respondent's Position

"The original bill denied with CPT 99205-95. Please see page 15 of MFDR, CPT incorrectly billed. We requested documentation to support the Telehealth visit. The provider has re-billed with the same documentation stating the service was performed in an office setting and continues to bill with a 95 modifier. Please request that the provider resubmit with corrected billing."

Response Submitted by: Mitchell an Enlyte Company

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 Texas Administrative Code (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:

- 16 – Claim/service lacks information or has submission billing error(s).
- 205 – The charge was disallowed as additional information/definition is required to clarify service/supply rendered.

Issues

Is the requestor entitled to reimbursement?

Findings

The requestor seeks reimbursement in the amount of \$433.11 for a new patient evaluation and management service, billed under CPT code 99205. The requestor appended modifier -95 which is described as, "95 - Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system."

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 §133.30 states "...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.”

The TDI, DWC’s website at www.tdi.texas.gov/wc/hcprovider/telemed.html states, “Billing – The health care provider must use Place of Service (POS) code 02 in box 24B of the CMS1500 02/12 to indicate that the service was delivered through telemedicine or telehealth and POS code 11 for any related DWC Form-073, Work Status Report.”

A review of the medical bill documents that the requestor billed the insurance carrier CPT code 99205 with modifier -95 and place of service -02. The DWC directs health care providers to use POS code -02 when billing for telemedicine and telehealth services.

The insurance carrier denied the payment with the reduction codes indicated above. A review of the new patient evaluation and management service finds the requestor has not documented that the injured employee was seen via a telemedicine visit. The DWC finds the requestor has not documented that the service in dispute was rendered via telemedicine. Because the documentation does not support the service rendered and billed, the DWC concludes the requestor failed to demonstrate that reimbursement is due.

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 requestor has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement in the amount of \$0.00.

Authorized Signature

_____ May 24, 2024
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, 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.