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
Great American Alliance Insurance Co.

MFDR Tracking Number
M4-24-1368-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
February 22, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 28, 2023	99213	$174.71	$174.71
November 28, 2023	99080-73	$15.00	$0.00
November 30, 2023	99361-W1	$113.00	$0.00
	Total	$302.71	$174.71

Requestor's Position

"Dates of service 11/28 & 11/30/2023 remain unpaid..."

Amount in Dispute: $302.71

Respondent's Position

"The services have been denied for several reasons including the fact that preauthorization was required for those services. This is because the services in question are outside of the ODG. This

is based upon the opinion of Dr. [name]. We are attaching a copy of Dr. [name]'s report. Additionally, the bills were denied on the basis of lack of information. The provider is not entitled to any reimbursement."

Response Submitted by: Flahive, Ogden & Latson

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 Medical Fee Dispute Resolution requests.
2. 28 TAC §133.10 sets out required billing forms/formats for health care provider billing procedures.
3. 28 TAC §129.5 sets out the guidelines for billing and reimbursement of Work Status Reports.
4. 28 TAC §134.203 sets fee guidelines for professional medical services.
5. 28 TAC §134.220 sets out the fee guidelines for case management services.

Denial Reasons

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

- 16 – CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION ERROR(S).
- 270 - NO ALLOWANCE HAS BEEN RECOMMENDED FOR THIS PROCEDURE/ SERVICE/SUPPLY.
- 270 – TREATMENT FALLS OUTSIDE ODG PER 11/27/23 PEER REVIEW WITH DR… AND REQUIRES PRE-CERT WHICH IS ABSENT.
- W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. Did the insurance carrier raise a new defense in its response?
2. Is the requestor entitled to reimbursement for CPT code 99213 rendered on November 28, 2023?
3. Is the requestor entitled to reimbursement for CPT code 99080-73, Work Status Report, rendered on November 28, 2023?
4. Is the requestor entitled to reimbursement for CPT code 99361-W1 rendered on November 30, 2023?

Findings

1. In its position statement, the respondent upholds the denial of the disputed services by raising the issue of lack of preauthorization. The respondent further states that the services in dispute are outside of the Official Disability Guidelines (ODG) based on a peer review.

   Per explanation of benefits dated January 3, 2024, DWC finds that the insurance carrier raised ODG issues for a CPT code, S9213, which is not on the submitted medical bills and is not in dispute.

   The response from the insurance carrier is required by 28 TAC §133.307 (d)(2)(F) to address only the denial reasons presented to the health care provider before the request for medical fee dispute resolution (MFDR) was filed with DWC. Any new denial reasons or defenses raised shall not be considered in this review.

   A review of the submitted documentation does not support that a denial based on lack of preauthorization or medical necessity was presented to the requestor before this request for MFDR was filed. Therefore, DWC will not consider this argument in the current dispute review.

2. The requestor is seeking reimbursement in the total amount of $174.71 for disputed CPT code 99213 rendered on November 28, 2023.

   A review of the submitted documentation finds that the requestor billed the insurance carrier $174.71 for CPT code 99213 on the disputed date of service. A review of the submitted explanation of benefits (EOB) documents finds that the insurance carrier denied reimbursement for this evaluation and management (E/M) service stating that the "claim/service lacks information or has submission errors."

   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 a low level of medical decision making."

   A review of the submitted documentation finds that on the disputed date of service the requestor appropriately documented an office visit meeting the description of CPT code 99213 as defined by the American Medical Association. A review of the medical bills submitted finds that the requestor submitted a complete medical bill in accordance with 28 TAC §133.10, which sets out required billing forms/formats for health care provider billing procedures.

   DWC finds that the insurance carrier's denial reason based on lack of information or billing errors is not supported. Therefore, DWC finds that the requestor is entitled to reimbursement for CPT code 99213 rendered on November 28, 2023.

   DWC finds that 28 TAC §134.203 applies to the billing and reimbursement of CPT code

99213.

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."

28 TAC §134.203(c) states in pertinent part, "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.

- The disputed date of service is November 28, 2023.
- The disputed service was rendered in zip code 75211, locality 11, Dallas; carrier 4412.
- The Medicare participating amount for CPT code 99213 in 2023 at this locality is $91.33.
- The 2023 DWC Conversion Factor is 64.83
- The 2023 Medicare Conversion Factor is 33.8872.
- Using the above formula, DWC finds the MAR is $174.72 for CPT code 99213 on the disputed date of service.
- The respondent paid $0.00.
- The requestor seeks $174.71; therefore, this amount is recommended for reimbursement of CPT code 99213 rendered on November 28, 2023.

3. The requestor is seeking reimbursement in the amount of $15.00 for CPT code 99080-73, DWC73 Work Status Report, rendered on November 28, 2023.

28 TAC §129.5(j)(1) which applies to the billing and reimbursement of Work Status Reports, 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)(2) and (3) 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; and (3) on the schedule requested by the insurance carrier, its agent, or the employer requesting the report through its insurance carrier…,"

A review of the medical records submitted does not support that there was a substantial change in the injured employee's work status or in their activity restrictions. The documentation submitted does not support the fact that the Work Status Report was filed upon an initial examination of the employee, as the office visit billed on the same date was for an established patient office visit. DWC finds no evidence that the Work Status Report was requested by the carrier or the employer.

DWC finds that the requestor is not entitled to reimbursement for CPT code 99080-73, Work Status Report, rendered on November 28, 2023.

4. The requestor is seeking reimbursement in the amount of $113.00 for CPT code 99361-W1 rendered on November 30, 2023. CPT code 99361, which represents a case management service, is described as "Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient not present); approximately 30 minutes." The requestor appended the CPT code 99361 with modifier W1, which indicates the service was provided and/or coordinated by the treating doctor.

   28 TAC §134.220 which sets out reimbursement guidelines for case management services, states in pertinent part "Case management responsibilities by the treating doctor are as follows: (1) Team conferences and telephone calls shall include coordination with an interdisciplinary team. (A) Team members shall not be employees of the treating doctor… (B) Team conferences and telephone calls must be outside of an interdisciplinary program. Documentation shall include the purpose and outcome of conferences and telephone calls, and the name and specialty of each individual attending the team conference or engaged in a phone call. (2) Team conferences and telephone calls should be triggered by a documented change in the condition of the injured employee and performed for the purpose of coordination of medical treatment and/or return to work for the injured employee… 4) Case management services require the treating doctor to submit documentation that identifies any health care provider that contributes to the case management activity. Case management

services shall be billed and reimbursed as follows: (A) CPT code 99361. (i) Reimbursement to the treating doctor shall be $113. Modifier "W1" shall be added. "

The submitted "Team Conference" report does not include the treating doctor signature or that he/she coordinated the case management; it does not specify that the team members are not employees of the treating doctor; the report does not document a change in the injured employee's condition triggering the need for a team conference.

DWC finds the requestor did not comply with the requirements outlined in 28 TAC §134.220, therefore the requestor is not entitled to reimbursement for CPT code 99361-W1 rendered on November 30, 2023.

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.

DWC finds the requestor has established that reimbursement in the amount of $174.71 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, the Division has determined the requestor is entitled to reimbursement for some of the disputed services. It is ordered that Great American Alliance Insurance Co., must remit to Peak Integrated Healthcare, $174.71 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature:

		March 27, 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 electronico CompConnection@tdi.tas.gov.