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
Berkshire Hathaway Homestate Insurance

MFDR Tracking Number
M4-24-1390-01

Carrier's Austin Representative
Box Number 12

DWC Date Received
February 27, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 27, 2023	99213	$174.71	$0.00
November 27, 2023	99080-73	$15.00	$0.00
	Total	$189.71	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They submitted a copy of their reconsideration dated February 27, 2024, that states, "We disagree that this office visit should be denied payment. There have been no disputes and a date of service after this office visit was paid in full."

Amount in Dispute: $189.71

Respondent's Position

Response dated March 11, 2024.

"The reason this date was not paid was due to UR's denial, indicated on page 11 of 14, under reduction explanation."

Response dated March 14, 2024.

"Please see attached response and supporting documentation for MFDR M4-24-1390-01."

"We are in receipt of your letter dated 3/4/24 advising that Peak Integrated Healthcare has requested Medical Fee Dispute Resolution (MFDR) for billed services of $189.71.

We are asking that the request for MFDR be reviewed. We have not come to a mutual agreement that resolves the billing dispute. Based up the attached UR determination #1139438 the office visit on date of service 11/27/23 was non-authorized. Please see the attached UR determination letter."

Response submitted by: Berkshire Hathaway Homestate Insurance 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 §134.600 sets out the requirements for preauthorization, concurrent utilization review, and voluntary certification of health care.
3. 28 TAC §133.240 sets out medical payments and denials.
4. 28 TAC §134.203 sets out the medical fee guidelines for professional services.
5. 28 TAC §129.5 details the requirements for work status reports.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- W3 – No additional reimbursement allowed after review of appeal/reconsideration.
- YE(P12) – Preauthorization requested but denied.
- P12 – Workers Compensation jurisdictional fee schedule adjustment.
- W3 – The benefit for this service is included in the payment/allowance for another service/procedure that has been performed on the same day.

Issues

1. Did the disputed service require prior authorization?

2. Did respondent meet requirements of utilization review?

3. Is the level of service supported by medical documentation?

4. Is the requestor entitled to reimbursement?

Findings

1. The requestor is seeking reimbursement of Code 99213 and 99080-73 for date of service November 27, 2023. The insurance carrier denied the disputed services as prior authorization requested but denied.

   The DWC will now determine whether the disputed service Code 99213 and 99080-73 rendered on November 27, 2023 required preauthorization pursuant to DWC Rule 28 TAC §134.600.

   DWC Rule TAC 28 §134.600(p) (1-12) states in pertinent part "(p) non-emergency health requiring preauthorization…"

   DWC Rule 28 §134.600(r)(1) states, "(r) The requestor and insurance carrier may voluntarily discuss health care that does not require preauthorization or concurrent utilization review under subsections (p) and (q) of this section respectively. (1) Denial of a request for voluntary certification is not subject to dispute resolution for prospective review of medical necessity."

   The DWC finds that office visits and work status reports do not require prior authorization and therefore, the insurance carrier's denial reason is not supported.

2. The respondent included a copy of a Utilization Review: Notice of Adverse Determination dated December 5, 2023 regarding date of service November 27, 2023. The document states, "…we decided that the requested services or treatments described below are not medically necessary or appropriate. This means that we do not approve these services of treatment."

   DWC Rule 28 TAC §133.240(q) states, "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 (relating to Notice of Determinations Made in Utilization Review). Additionally, in any instance where 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 if this title (relating to Requirements Prior to Issuing Adverse Determination), including the requirement that prior 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 or, in cases of a dental plan or chiropractic services, with a dentist or chiropractor, respectively."
   Review of the submitted documentation found none of the submitted explanation of benefits indicated the services were not medically necessary or that prior to issuing the adverse

determination, the insurance carrier afforded the health care provider a reasonable opportunity to discuss the billed health care with a doctor.

DWC finds the insurance carrier did not meet the requirements of applicable rules prior to issuing the adverse determination and therefore, the denial reason is not supported.

3. The requestor is seeking reimbursement in the total amount of $174.71 for CPT Code 99213 – and $15.00 for Code 99080-73 rendered on November 27, 2023.

DWC Rule 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 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 low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded."."
The American Medical Association (AMA) CPT Code and Guideline Changes, effective January 1, 2021, can be found at: https://www.ama-assn.org/system/files/2019-06/cptoffice-prolonged-svs-code-changes.pdf.

In summary, CPT 99213 documentation must contain appropriate history and/or examination and low level of medical decision making.

An interactive E&M scoresheet tool is available at: www.novitas-solutions.com/webcenter/portal/MedicareJL/EMScoreSheet.

A review of the submitted medical documentation found the number and complexity of problems(s) that were addressed during the encounter was low, the amount and/or complexity of data reviewed was minimal and the risk of complications and/or morbidity or mortality of patient management was minimal. The consideration of all these factors results in "straightforward" decision making. For these reasons, medical documentation submitted did not meet AMA criteria for reimbursement of CPT code 99213. No payment is recommended.

DWC Rule §129.5(e) states, "The doctor, delegated physician assistant, or delegated advanced practice registered nurse shall file the Work Status Report:

(1) after the initial examination of the injured employee, regardless of the injured employee's work status.

(2) when the injured 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, which shall not exceed one report every two weeks, and which shall be based upon the doctor's, delegated physician assistants, or delegated advanced practice registered nurse's scheduled appointments with the injured employee.

A review of the submitted documentation found none of the provisions listed above apply to the submitted patient encounter dated November 27, 2023. No payment is recommended.

4. DWC finds that the submitted documentation does not support the payment of CPT Code 99213 or 99080-73. No payment is recommended.

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 requester 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 $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 3, 2024 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.