TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Peak Integrated Healthcare

Respondent Name
Safety National Casualty Corp.

MFDR Tracking Number
M4-24-2458-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
July 8, 2024

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
May 29, 2024	99213	$185.89	$185.89
May 29, 2024	99080-73	$15.00	$15.00
	Total	$200.89	$200.89

Requestor's Position

"...after reconsideration this was again denied payment stating, 'extent of injury', however, we have payment for the same treatment for an office visit after this one..."

Amount in Dispute: $200.89

Respondent's Position

The Austin carrier representative for Safety National Casualty Corp. is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on July 16, 2024. Per 28 Texas Administrative Code §133.307 (d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information. As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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) §133.305 sets out general Medical Dispute Resolution guidelines.
3. 28 TAC §124.2 sets out Insurance Carrier Notification Requirements.
4. 28 TAC §134.600 sets out the procedures for preauthorization requirements of healthcare services.
5. 28 TAC §134.203 sets out the fee guideline for professional medical services.
6. 28 TAC §129.5 sets out the fee guidelines for the DWC73 Work Status Reports.

Denial Reasons

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

- 190 – BILLING FOR REPORT AND/OR RECORD REVIEW EXCEEDS REASONABLENESS.
- S264 – PAYMENT DENIED. SERVICE NOT AUTHORIZED.
- 197 – PAYMENT DENIED/REDUCED FOR ABSENECE OF PRECERTIFICATION/ AUTHORIZATION.
- P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- N600 – ADJUSTED BASED ON THE APPLICABLE FEE SCHEDULE FOR THE REGION IN WHICH THE SERVICE WAS RENDERED.
- 1014 – THE ATTACHED BILLING HAS BEEN RE-EVALUATED AT THE REQUEST OF THE PROVIDER. 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.
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 219 – BASED ON EXTENT OF INJURY.
- W3 – BILL IS RECONSIDERATION OR APPEAL.

Issues

1. Are the disputed services eligible for review by Medical Fee Dispute Resolution (MFDR)?
2. Is the insurance carrier's denial reason based on absence of preauthorization supported?
3. Is the insurance carrier's denial reason of CPT code 99080-73 based on service exceeds reasonableness supported?
4. Is the requestor entitled to reimbursement for CPT code 99213?
5. Is the requestor entitled to reimbursement for CPT code 99080-73?

Findings

1. A review of the submitted explanation of benefits (EOB) documents submitted finds that the services in dispute were denied payment by the insurance carrier in part due to "extent of injury."

   28 TAC §133.305(b) states, "Dispute Sequence. If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability, or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021."

   28 TAC §133.307(d)(2)(H) requires that if the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with Rule §124.2 (relating to carrier reporting and notification requirements).

   28 TAC §124.2(h) requires notification to the division and claimant of any dispute of disability or extent of injury using plain language notices (PLN) with language and content prescribed by the division. Such notices "… shall provide a full and complete statement describing the carrier's action and its reason(s) for such action. The statement must contain sufficient claim-specific substantive information to enable the employee/legal beneficiary to understand the carrier's position or action taken on the claim."

   The review of the submitted documentation finds no copies, as required by Rule §133.307(d)(2)(H), of any PLN-11 or PLN 1 notices issued in accordance with Rule §124.2. The insurance carrier's denial reason is therefore not supported. DWC concludes that based on submitted documentation, there are no outstanding issues of compensability, extent, or liability for the injury.

   DWC finds that the disputed services are eligible for review by MFDR.

2. The insurance carrier denied CPT code 99213 and 99080-73 rendered on May 29, 2024, in part citing reason codes related to absence of preauthorization.

   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 (MDM). When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter."

   CPT code 99080-73 is described as "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form." In

this case, 99080-73 specifically refers to the rendering of a DWC specific Work Status Report.

28 TAC §134.600(p) sets out the non-emergency professional medical services that require preauthorization. Evaluation and management services and Work Status Reports are not included in the list of services requiring preauthorization in accordance with 28 TAC §134.600(p).

DWC finds that CPT codes 99213 and 99080-73 rendered on May 29, 2024, did not require preauthorization and therefore, the denial reason is not supported.

3. The insurance carrier denied payment for CPT code 99080-73 rendered on May 29, 2024, citing that billing for the Work Status Report "exceeds reasonableness."

   28 TAC §129.5 which applies to the disputed Work Status Report, states in pertinent part "(b) If authorized under their licensing act, a treating doctor may delegate authority to complete, sign, and file a work status report to a licensed physician assistant or a licensed advanced practice registered nurse as authorized under Texas Labor Code §408.025(a-1). The delegating treating doctor is responsible for the acts of the physician assistant and the advanced practice registered nurse under this subsection…

   > (e) 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…
   >
   > (J)… 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 that the disputed DWC 73, Work Status Report, rendered on May 29, 2024, met the documentation and medical billing requirements outlined in 28 TAC §129.5. Therefore, DWC finds that the insurance carrier's denial reason based on "exceeds reasonableness" is not supported.

4. The requestor is seeking reimbursement in the amount of $185.89 for disputed CPT code 99213 rendered on May 29, 2024. Because the insurance carrier's denial reasons are not supported, DWC finds that the requestor is entitled to reimbursement.

   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 (MDM). When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter."

   DWC finds that 28 TAC §134.203 applies to the billing and reimbursement of disputed service 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 May 29, 2024.
- The disputed service was rendered in zip code 75043, locality 11, Dallas; carrier 4412.
- The Medicare participating amount for CPT code 99213 in 2024 at this locality is $91.25.
- The 2024 DWC Conversion Factor is 67.81.
- The 2024 Medicare Conversion Factor on the disputed date of service is 33.2875.
- Using the above formula, DWC finds the MAR is $185.89 for CPT code 99213 on the disputed date of service.
- The respondent paid $0.00.
- Reimbursement in the amount of $185.89 is recommended for CPT code 99213 rendered on the disputed date of service.

5. The requestor is seeking reimbursement in the amount of $15.00 for CPT code 99080-73, Work Status Report, rendered on May 29, 2024. Because the insurance carrier's denial reasons are not supported, as per findings number two and three above, DWC finds that the requester is entitled to reimbursement in the amount of $15.00 for CPT code 99080-73 rendered on May 29, 2024.

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 total amount of $200.89 is due.

ORDER

Under Texas Labor Code §§413.031, the DWC has determined the requestor is entitled to reimbursement for disputed services. It is ordered that Safety National Casualty Corp. must remit to Peak Integrated Healthcare, $200.89 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		October 9, 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, 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.