



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

SUMMIT REHABILITATION CENTERS

Respondent Name

EMPLOYERS MUTUAL CASUALTY COMPANY

MFDR Tracking Number

M4-06-5960-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

May 17, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DOS 12/23/05: No EOB were provided by carrier to understand position for current charges. . . . DOS 9/2/05, 10/3/05, 12/2/05 and 2/7/06: The provider followed all fee guidelines to bill for services. . . . DOS 11/2/05 and 1/26/06: Services and office visit is well informed here, and during billing for reconsideration"

Amount in Dispute: \$246.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Rule 129.5(d) indicates that a work status report is only to be issued 1) after the initial exam, 2) when there is a change in status or substantial change in activity restrictions and 3) as requested by the carrier. The provider has not provided justification to fulfill any of these elements. . . . With respect to CPT code 96004, the provider failed to provide sufficient information to justify reimbursement for a motion analysis. . . . With respect to CPT code 99070, there is no evidence that this bill was received by the carrier. No EOB exists. . . . Lastly, CPT code 99213 exceeds the applicable fee guidelines and was appropriately reduced."

Response Submitted by: Flahive, Ogden & Latson, 505 West 12th Street, Austin, Texas 78701

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 2, 2005 to February 7, 2006	Professional Medical Services	\$246.50	\$20.35

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §129.5 sets out guidelines regarding work status reports.
3. 28 Texas Administrative Code §133.301 sets out the procedures for insurance carrier review of medical bills.
4. 28 Texas Administrative Code §134.1 sets forth general provisions related to use of the fee guidelines.

5. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
6. 28 Texas Administrative Code §134.202 sets out the fee guidelines for professional medical services.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 218 – REPORT CHARGE WAS DENIED AS IT DOES NOT FALL WITHIN THE REPORT GUIDELINES PER TWCC RULES.
 - 284 – NO ALLOWANCE WAS RECOMMENDED AS THIS PROCEDURE HAS A MEDICARE STATUS OF 'B' (BUNDLED).
 - No change in work status as been documented.
TID Rule 129.5 (d) (2) has not been met; therefore TWCC-73 charge is not payable.
 - REVIEWED BY OUR NURSE REVIEW. THE FORM WAS INCOMPLETE THEREFORE NOT VALID.
 - 42 – CHARGES EXCEED OUR FEE SCHEDULE OR MAXIMUM ALLOWABLE AMOUNT.
 - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE
 - 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
 - THIS CLAIM HAS BEEN REVIEWED BY OUR NURSE REVIEW UNIT. THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT 96004 AS BEING BILLED. PLEASE RESUBMIT WITH ADDITIONAL INFORMATION.
 - 17 – PAYMENT ADJUSTED BECAUSE REQUESTED INFORMATION WAS NOT PROVIDED OR WAS INSUFFICIENT/INCOMPLETE. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE.
 - 296 – THE REPORT CHARGE WAS DENIED BASED ON DWC GUIDELINES REQUIRING REPORT BE SUBMITTED ON REQUIRED FORMS.
 - 373 – BASED ON THE AVAILABLE INFORMATION, THE SERVICES RENDERED APPEAR TO BEST BE DESCRIBED BY THIS CODE. . . . OUR NURSE REVIEW UNIT HAS DETERMINED PROCEDURE CODE 99212 IS DOCUMENTED.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. Is additional reimbursement supported for the disputed work status reports?
3. Is additional reimbursement supported for disputed procedure code 96004?
4. Is additional reimbursement supported for disputed procedure code 99070?
5. Did the insurance carrier appropriately reduce payment for disputed evaluation code 99213?
6. What is the recommended payment amount for the services in dispute?
7. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code 42 – “CHARGES EXCEED OUR FEE SCHEDULE OR MAXIMUM ALLOWABLE AMOUNT.” Review of the submitted information finds no documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. The insurance carrier denied reimbursement for disputed work status reports, procedure code 99080-73, dates of service September 2, 2005, October 3, 2005, December 2, 2005, and January 26, 2006, using denial reason codes 218 – “REPORT CHARGE WAS DENIED AS IT DOES NOT FALL WITHIN THE REPORT GUIDELINES PER TWCC RULES.”; 284 – “NO ALLOWANCE WAS RECOMMENDED AS THIS PROCEDURE HAS A MEDICARE STATUS OF 'B' (BUNDLED).”; 296 – “THE REPORT CHARGE WAS DENIED BASED ON DWC GUIDELINES REQUIRING REPORT BE SUBMITTED ON REQUIRED FORMS.”; 17 – “PAYMENT ADJUSTED BECAUSE REQUESTED INFORMATION WAS NOT PROVIDED OR WAS INSUFFICIENT/INCOMPLETE. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE.”; with additional notation that “No change in work status as been documented. TID Rule 129.5 (d) (2) has not been met; therefore TWCC-73 charge is not payable.” Per 28 Texas Administrative Code §129.5(d), “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 (carrier), its agent, or the employer requesting the report through its carrier, which shall not to exceed one report every two weeks and which shall be based upon the doctor’s scheduled appointments with the employee.” Review of the submitted work status reports finds that the reports were not submitted in relation to an initial examination of the employee. The reports document neither a change in work status nor a substantial change in activity restrictions. No documentation was found to support that the reports were requested by the insurance carrier, its agent, or the employer. The Division concludes that the insurance carrier’s denial reasons are supported. Reimbursement is not recommended.

3. The insurance carrier denied disputed procedure code 96004, service date November 2, 2005, with reason codes 16 – "CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE"; and 225 – "THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION."; with additional notation that "THIS CLAIM HAS BEEN REVIEWED BY OUR NURSE REVIEW UNIT. THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT 96004 AS BEING BILLED. PLEASE RESUBMIT WITH ADDITIONAL INFORMATION." Per Medicare payment policy, procedure code 96004 is defined as "physician review and interpretation of comprehensive computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report. Motion analysis is performed in a dedicated motion analysis laboratory (ie, a facility capable of performing videotaping from the front, back and both sides, computerized 3-D kinematics, 3-D kinetics, and dynamic electromyography)." Review of the clinical notes submitted by the requestor finds that the tests reviewed by the physician were not performed in a dedicated motion analysis laboratory and did not meet the description of the required tests as set out in the definition of the procedure. The documentation submitted by the requestor does not support the service as billed. The insurance carrier's denial reasons are supported. Reimbursement is not recommended.
4. For disputed procedure code 99070, service date December 23, 2005, the requestor asserts that "No EOB were provided by carrier to understand position for current charges." The respondent argues that "there is no evidence that this bill was received by the carrier. No EOB exists." Review of the submitted documentation finds as follows:
- Neither the requestor nor the respondent has provided an explanation of benefits regarding the insurance carrier's final action on procedure code 99070.
 - 28 Texas Administrative Code §133.307(e)(2)(B), effective January 1, 2003, 27 *Texas Register* 12282, requires that the request shall include "a copy of each explanation of benefits (EOB) . . . relevant to the fee dispute or, if no EOB was received, convincing evidence of carrier receipt of the provider request for an EOB." Review of the of the submitted documentation finds that the request for reconsideration letter, dated April 11, 2006, includes a statement that "DOS 12/23/05: No EOB were provided by carrier to understand position for current charges. . . . If payment has been issued for these services, and we are in error, please provide a copy of the front and back of the check and any related documentation." Additionally, the requestor sent a certified mail receipt signed by a representative of the insurance carrier supporting that the request letter was received on April 17, 2006. Accordingly, the Division finds that the requestor has submitted convincing evidence of carrier receipt of the provider request for an EOB. The Division therefore concludes that the requestor has met the requirements of §133.307(e)(2)(B).
 - However, disputed procedure code 99070 is defined as "Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)." Review of the submitted documentation finds no list, description, or any indication of the supplies or materials rendered. The submitted documentation does not support the service as billed.
 - Further, procedure code 99070 represents a product or service for which CMS or the Division has not established a relative value unit or payment amount. Reimbursement is therefore subject to the provisions of former 28 Texas Administrative Code §134.1(c), effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
 - No documentation was found to support that payment of the amount sought would be a fair and reasonable rate of reimbursement for the disputed item.
 - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The Division concludes that the requestor has not supported the additional requested reimbursement for disputed procedure code 99070. Payment is not recommended.

5. The insurance carrier reduced payment for evaluation code 99213, service date February 7, 2006, with reason code 373 – "BASED ON THE AVAILABLE INFORMATION, THE SERVICES RENDERED APPEAR TO BEST BE DESCRIBED BY THIS CODE. . . . OUR NURSE REVIEW UNIT HAS DETERMINED PROCEDURE CODE 99212 IS DOCUMENTED." The requestor asserts that "The provider followed all fee guidelines to bill for services." The respondent argues that "CPT code 99213 exceeds the applicable fee guidelines and was appropriately reduced." The definition of evaluation and management code 99213 is "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the

presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family." Review of the submitted clinical notes finds that the health care provider has documented an expanded problem focused history in accordance with Medicare payment policy. However—even though the provider has recorded the words "Expanded Problem Focused Examination" in the notes—the notes do not reflect the elements necessary to meet the Medicare payment policy requirements for an expanded problem focused examination. Even so, the notes do meet the Medicare payment policy documentation requirements for medical decision making of low complexity; as such, the documentation does support at least two of the required two out of three key components. The Division therefore finds that the submitted documentation supports procedure code 99213 as billed. Furthermore, per 28 Texas Administrative Code §133.301(b), effective July 15, 2000, 25 *Texas Register* 2115, "Neither the insurance carrier nor the carrier's agent shall change a billing code on a medical bill or reimburse treatment(s) and/or service(s) at another billing code's value unless the insurance carrier contacts the sender of the bill and the sender agrees to the change." No documentation was found to support that the health care provider agreed to the insurance carrier's change of the billing code from 99213 to 99212, or agreed to accept reimbursement of the service at the other billing code's value. The insurance carrier's payment reduction is not supported. Reimbursement will therefore be calculated according to the applicable Division fee guideline.

6. Per 28 Texas Administrative Code §134.202(c), effective January 5, 2003, 27 *Texas Register* 4048 and 12304 "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%." The 2006 Medicare payment rate for procedure code 99213 performed in Dallas, Texas is \$54.60. This amount multiplied by 125% is \$68.25.
7. The total recommended payment for the services in dispute is \$68.25. This amount less the amount previously paid by the insurance carrier of \$47.90 leaves an amount due to the requestor of \$20.35. This amount is recommended.

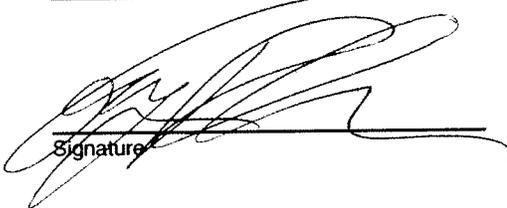
Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$20.35.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$20.35 plus applicable accrued interest per 28 Texas Administrative Code §134.803, and/or §134.130 if applicable, due within 30 days of receipt of this Order.

Authorized Signature



Signature

Grayson Richardson
Medical Fee Dispute Resolution Officer

May 30, 2014
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.