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 and Address

STEPHEN J RINGEL MD PA
107 W 30TH AVE
PAMPA TX 79065

Respondent Name

ACE AMERICAN INSURANCE CO

Carrier's Austin Representative Box

Box Number 15

MFDR Date Received

OCOTBER 1, 2007

MFDR Tracking Number

M4-08-0818-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We do not have a PPO contract."

Amount in Dispute: $72.93

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Susan please see below info from First Health. Per nat., provider was with CCN effective 12/1/05-12/31/07, which would be during the dos in dispute."

Response Submitted by: Josie Bloss, Medical Dispute Specialist Syracuse WC Claims Xchange Center

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 26, 2007	CPT Code 99202-25 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or 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, 20 minutes are spent face-to-face with the patient and/or family	$25.52	$14.58
April 26, 2007	CPT Code 20605 Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)	$12.87	$12.86
April 26, 2007	HCPCS Code J0702 Injection, betamethasone acetate 3 mg and betamethasone sodium phosphate 3 mg	$1.66	$1.66

April 26, 2007	CPT Code 99080-73 Work Status Report	$3.00	$3.00
May 3, 2007 May 21, 2007	CPT Code 99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or 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 self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.	$14.94/each	$17.06
TOTAL		$72.93	$49.16

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 a medical fee dispute.
2. Former 28 Texas Administrative Code §134.202, effective August 1, 2003, sets the reimbursement guidelines for the disputed services.
3. 28 Texas Administrative Code §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
4. Former 28 Texas Administrative Code §134.1, effective May 2, 2006, provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
5. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines The services in dispute were reduced/denied by the respondent with the following reason codes.

   The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 45-Charges exceed your contracted/legislated fee arrangement. The charges have been priced in accordance to your fee for service contract with First Health.

Issues

1. Does a contractual agreement issue exist in this dispute?
2. Is the requestor entitled to additional reimbursement for CPT codes 99202, 20605, and 99212?
3. Is the requestor entitled to additional reimbursement for HCPCS code J0702?
4. Is the requestor entitled to additional reimbursement for CPT code 99080-73?

Findings

1. According to the submitted explanations of benefits, the insurance carrier reduced or denied disputed services with reason codes "45-Charges exceed your contracted/legislated fee arrangement. The charges have been priced in accordance to your fee for service contract with First Health." Review of the submitted information found no documentation to support that the disputed services were subject to a contractual agreement between the parties to this dispute. On October 27, 2011, the Division requested the respondent to provide a copy of the referenced contract between the network and the health care provider, pursuant to Division rule at 28 TAC §133.307(l), which states that "The commission may request other additional information from either party to review the medical fee issues in dispute. The other additional information shall be received by the division within 14 days of receipt of this request." The respondent failed to provide a copy of the additional requested documents. The respondent has not supported the above denial/reduction explanations. For this reason, the disputed services will be reviewed for payment in accordance with applicable Division fee

guidelines.

2. 28 Texas Administrative Code §134.202(b) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section."

   28 Texas Administrative Code §134.202(c)(1) states "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: "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%."

   According to the submitted medical bills, the services were performed in Pampa, Texas; therefore, the Medicare carrier locality is "Rest of Texas."

CPT CODE	MEDICARE ALLOWABLE	MEDICARE ALLOWABLE x 125%	TOTAL NUMBER OF UNITS	TOTAL MAR	TOTAL PAID	AMOUNT DUE
99202	$58.32	$72.90	1	$72.90	$58.32	$14.58
20605	$51.46	$64.32	1	$64.32	$51.46	$12.86
99212	$34.15	$42.68	2	$85.36	$68.30	$17.06

3. 28 Texas Administrative Code §134.202(c) states "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (2) for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthethics, Orthotics and Supplies (DMEPOS) fee schedule;

   According to the DMEPOS fee schedule, HCPCS code J0702 has a fee schedule of $5.190. In accordance with 28 Texas Administrative Code §134.202(c)(2), $5.190 X 125% = $6.48. The difference between amount due and paid is $1.66; this amount is recommended for additional reimbursement.

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

   28 Texas Administrative Code §129.5(i)(1) 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 Texas Administrative Code §129.5 (d)(1) and (2) states "The doctor shall file the Work Status Report:
   (1) after the initial examination of the employee, regardless of the employee's work status."

   Per 28 Texas Administrative Code §129.5 (d)(1) this report was required because it was filed after the initial examination. Per 28 Texas Administrative Code §129.5, the work status report has a MAR of $15.00. The respondent paid $12.00. The difference between the MAR and amount paid results in an additional reimbursement of $3.00.

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 $49.16.

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 $49.16 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		2/28/2014
Signature	Medical Fee Dispute Resolution Officer	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.