



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ELITE HEALTHCARE NORTH DALLAS
P.O. BOX 1210
FRISCO, TX 75034

Respondent Name

RICHARDSON ISD

MFDR Tracking Number

M4-13-1320

Carrier's Austin Representative

Box Number 53

MFDR Date Received

JANUARY 25, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached date of service 1/2/12 was not paid with the correct price. The conversion factor changed and went into effect 1/1/12. Please remit the remaining balance. Dates of services 1/13/12, 1/26/12, 2/17/12, 2/20/12 were denied due to 'extent.' I spoke to the adjuster on 4/12/12 and was told Dr. Williams stated the patient had a new injury on [date]. THIS IS INCORRECT...THIS IS NOT A NEW INJURY...Date of service 2/27/12 was never processed or we never received the EOB. I have attached the original claim with the original date that it was sent."

Amount in Dispute: \$2,076.95

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated January 8, 2013: "Based on our review our position remains unchanged and we continue to stand by our PLN 11 of January 31, 2012 and denial of bills since that date."

Response Submitted by: Tristar Risk Management

Respondent's Supplemental Position Summary dated February 8, 2013: "Information was received concerning the claimant suffering an intervening injury; therefore, a PLN-11 was filed by our client Tristar Risk Management, on behalf of Richardson ISD. The subsequent injury was not in the course and scope of the claimant's employment at Richardson ISD. The PLN-11 has not been overturned; therefore, no additional payment is due at this time."

Response Submitted by: Review Med

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Rows include services from November 16, 2010 and January 2, 2012.

January 13, 2012	CPT Code 99214-25	\$168.79	\$0.00
January 26, 2012 February 17, 2012 February 20, 2012	CPT Code 99213-25	\$114.17	\$0.00
January 26, 2012 June 26, 2012 July 10, 2012 August 9, 2012	CPT Code 99080-73	\$15.00	\$0.00
February 17, 2012 February 27, 2012 August 9, 2012 August 23, 2012	CPT Code 97112-GP(x2)	\$104.16	\$98.94
February 17, 2012 February 27, 2012 August 9, 2012 August 23, 2012	CPT Code 97110-GP(x2)	\$99.72	\$90.02
June 26, 2012	CPT Code 99214-25	\$168.87	\$0.00
July 10, 2012 August 9, 2012 September 4, 2012	CPT Code 99213	\$114.25	\$0.00
TOTAL		\$2,076.95	\$188.96

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 §134.204, effective March 1, 2008, sets out medical fee guidelines for workers' compensation specific services.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
4. 28 Texas Administrative Code §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 222-Charge exceeds Fee Schedule allowance.
 - 434-Modifier-73 was used to identify work status reports.
 - W1-Workers compensation jurisdictional fee schedule adjustment.
 - 219 – Based on extent on injury.

Issues

1. Did the requestor waive the right to medical fee dispute resolution for dates of service November 16, 2010 and January 2, 2012?
2. Did the medical fee dispute referenced above contain information/documentation that indicates that there are **unresolved** issues of Extent of Injury? Are the disputed services eligible for review by Medical Fee Dispute Resolution?
3. Was the dispute for dates of service February 27, 2012 and July 10, 2012 filed in the form and manner required by 28 Texas Administrative Code §133.307?
4. Is the requestor entitled to reimbursement for services rendered on February 27, 2012 and July 10, 2012?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and

may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the services in dispute are November 16, 2010 through September 4, 2012. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on January 25, 2013. Dates of service November 16, 2010 and January 2, 2012 are later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for dates of service November 16, 2010 and January 2, 2012.

2. Based upon the submitted explanation of benefits, the respondent denied reimbursement for services rendered on January 13, January 26, February 17, February 20, June 26, August 9, August 23, and September 4, 2012 based upon reason code "219 – Based on extent on injury."

Unresolved extent-of-injury dispute: The medical fee dispute referenced above contains unresolved issues of extent-of-injury for the same service(s) for which there is a medical fee dispute. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response(s) during the medical billing process.

Dispute resolution sequence: 28 Texas Administrative Code §133.305(b) requires that extent-of-injury disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(f) (3) (C) provides for dismissal of a medical fee dispute if the request for the medical fee dispute contains an unresolved extent of injury dispute for the claim. 28 Texas Administrative Code § 133.307(c) (2) (K) provides that a request for a medical fee dispute must contain a copy of each EOB related to the dispute.

Extent-of-injury dispute process: The Division hereby notifies the requestor that the appropriate process to resolve the issue(s) of CEL, including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1.

The division finds that due to the unresolved extent of injury issues for the above listed dates, the medical fee dispute request is not eligible for review until a final decision has been issued in accordance with 28 Texas Administrative Code §133.307 and §141.1.

Dismissal provisions: 28 Texas Administrative Code § 133.307(f) (3) provides that a dismissal is not a final decision by the Texas Department of Insurance, Division of Workers' Compensation ("Division"). The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code § 133.307. 28 Texas Administrative Code § 133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals, on the extent-of-injury dispute.

3. Neither party to the dispute submitted copies of explanation of benefits for dates of service February 27 and July 10, 2012. 28 Texas Administrative Code §133.307(c)(2)(B) requires the requestor to submit "a copy of each explanation of benefits (EOB), in a paper explanation of benefits format, relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB." The requestor submitted documentation to support a request for payment and/or an explanation of benefits was requested for these dates. The Division finds that the requestor submitted the dispute in accordance with 28 Texas Administrative Code §133.307 therefore, the disputed services will be reviewed in accordance with the Division's rules and medical fee guideline.
4. The requestor billed the respondent codes 97112-GP and 97110-GP on February 27, 2012, and 99213 and 99080 on July 10, 2012.

28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

- CPT code 97112 is defined as "Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities."

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the 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. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

On the disputed dates of service, the requestor billed CPT codes 97110 and 97112. CMS published Medical Learning Network (MLN) Matters, effective January 1, 2011 which states in part "Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The Centers for Medicare & Medicaid Services (CMS) is applying a MPPR to the practice expense payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures, furnished to the same patient on the same day, full payment is made for work and malpractice and 80 percent payment for the PE for services furnished in office settings and other non-institutional settings and at 75 percent payment for the PE services furnished in institutional settings." The multiple procedure rule discounting applies to the disputed service.

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

Review of Box 32 on the CMS-1500 the services were rendered in zip code 75254, which is located in Dallas, Texas; therefore, the Medicare participating amount is based on locality "Dallas, Texas".

The 2012 DWC conversion factor for this service is 54.86.

The 2012 Medicare Conversion Factor is 34.0376.

The Medicare Participating Amount for this code is \$32.35

Using the above formula and multiple procedure rule discounting policy, the Division finds the MAR for 97112 is $\$52.15 \times 2 = \98.94 . The respondent paid \$0.00. As a result, \$98.94 is recommended for reimbursement.

- CPT code 97110 is defined as "Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility."

The Medicare Participating Amount for this code is \$30.97.

Using the above formula and multiple procedure rule discounting policy, the Division finds the MAR for 97110 is $\$49.92 \times 2 = \99.84 . The respondent paid \$0.00. As a result, \$99.84 is recommended for reimbursement

- CPT code 99213 is defined as "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."

A review of the submitted medical report does not support the documentation requirement which require at least 2 of the 3 key components; As a result, reimbursement is not recommended.

- 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 §134.204 (l) states "The following shall apply to Work Status Reports. When billing for a Work Status Report that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section, refer to §129.5 of this title (relating to Work Status Reports)."

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;

(2) when the employee experiences a change in work status or a substantial change in activity restrictions."

A review of the June 26 and July 10, 2012 work status reports finds no change in the claimant's work status. The claimant remained off work. The Division finds no reimbursement is due per 28 Texas Administrative Code §129.5 (d)(2).

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 \$188.96.

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 \$188.96 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	10/16/2015
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 in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request 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 §141.1(d).

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