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
ELITE HEALTHCARE FORT WORTH

Respondent Name
TARRANT COUNTY HOSPITAL DISTRICT

MFDR Tracking Number
M4-13-2337-01

Carrier's Austin Representative
BOX NUMBER: 19

MFDR Date Received
MAY 13, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Attached please find claims that have been submitted to the Insurance Company. These have come back as denied for several different reasons. First being that they were previously paid, to duplicates, and other bogus reasons. This is an approved case with several DOS that have been paid. Body areas are approved, no disputed on this case."

Amount in Dispute: $3,176.42

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This medical dispute concerns reimbursement for medical treatment the requestor provided to the claimant between January 4, 2013 and February 26, 2013. The requestor has billed in excess of $3500 for the services in question, and asserts it is entitled to reimbursement in excess of $3000. The carrier has reimbursed the requestor more than $400, and submits that all fee reductions were made in accordance with the applicable fee guidelines, and with the consideration of whether the medical treatment was offered for the compensable diagnoses… The carrier would further note that requestor's charges exceed the applicable fee guidelines. The requestor has engaged in unbundling, which means the requestor has billed separately for services that should be billed and reimbursed together. The requestor is not entitled to additional reimbursement as a result of billing for included services separately."

Response Submitted by: FLAHIVE, OGDEN & LATSON

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 4, 2013	CPT Code 99213-25	$111.59	$0.00
February 14, 2013 February 20, 2013	CPT Code 99213-25	$232.02	$0.00
January 4, 2013 February 14, 2013	CPT Code 99080-73	$30.00	$15.00
January 15, 2013	CPT Code 97001-GP	$116.71	$116.71
January 16, 2013	CPT Code 76881	$197.80	$197.80

January 28, 2013 through February 11, 2013	CPT Code 97140-GP	$383.80	$346.32
February 18, 2013 through February 26, 2013	CPT Code 97140-GP	$479.32	$0.00
January 28, 2013 through February 11, 2013	CPT Code 97110-GP	$407.92	$0.00
February 14, 2013 through February 26, 2013	CPT Code 97110-GP	$921.22	$0.00
February 18, 2013 through February 26, 2013	CPT Code 97112-GP	$426.84	$0.00
February 26, 2013	CPT Code 97002-GP	$67.58	$0.00

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. Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for E/M services.
3. 28 Texas Administrative Code §129.5 sets out the procedures for filing a Work Status Report.

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

- 119 – Benefit Maximum for this time period or occurrence has been reached.
- QA – The amount adjusted is due to bundling or unbundling of services.
- W1 – Workers Compensation State Fee Schedule adjustment.
- 11 – The diagnosis is inconsistent with the procedure.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 828 – Chiropractic treatment exceeds 24 limitation for injuries occurring on or after January 1, 2004.
- 247 – A payment or denial has already been recommended for this service.
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
- PI – These are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not reasonable or necessary.
- 282 – This charge does not appear to be related to the injured and/or diagnosis. We will re-evaluate this charge upon receipt of clarifying information.
- 15 – Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
- 168 – Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services.
- 293 – This procedure requires prior authorization and none was identified.
- 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.

Issues

1. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Are office visits and physical therapy for dates of service February 14, 2013 through February 26, 2013 eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?
3. Did the requestor meet the requirements of 28 Texas Administrative Code §134.203?

4. Did the requestor meet the requirements of 28 Texas Administrative Code §129.5?
5. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "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."

2. 28 Texas Administrative Code §133.307(e)(3)(H) requires that if the carrier has raised a dispute pertaining to compensability, extent of injury, or liability for the claim, the Division shall notify the parties of the review requirements pursuant to §124.2 of this title, and will dismiss the request until those disputes have been resolved by a final decision, inclusive of all appeals. The appropriate dispute process for unresolved issues of compensability, extent and/or liability requires filing for a Benefit Review Conference pursuant to 28 Texas Administrative Code §141.1 prior to requesting medical fee dispute resolution.Review of the submitted documentation finds that there are unresolved issues of compensability, extent and/or liability for offices visits and physical therapy for dates of service February 14, 2013 through February 26, 2013 in this medical fee dispute. Documentation was not submitted to support that the issue(s) of compensability, extent and/or liability have been resolved prior to the filing of the request for medical fee dispute resolution. The requestor has failed to support that the office visits and physical therapy for dates of services February 14, 2013 through February 26, 2013 are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.
   For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning liability for the injured employee's workers' compensation claim, compensability of that claim, and/or extent-of-injury issues with that claim have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 410 prior to the submission of a medical fee dispute request for February 14, 2013 through February 26, 2013. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment for the office visits and physical therapy for February 14, 2013 through February 26, 2013. As a result, no amount is ordered.

3. 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, "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; … and other payment policies in effect on the date a service is provided…"
   - Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient. The American Medical Association (AMA) CPT code description for 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.

     The 1997 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare policy. It describes the documentation requirements for the service in dispute. Review of the documentation for date of service January 4, 2013 finds the following:
   - Documentation of the Expanded Problem Focused History
     - History of Present Illness (HPI) consists of one to three elements of the HPI. Documentation found listed no chronic conditions, thus this component was not met.
     - Review of Systems (ROS) inquires about the system directly related to the problem(s) identified in the HPI. Documentation was not found. This component was not met.
     - Past Family, and/or Social History (PFSH) are not applicable.
   - Documentation of a Expanded Problem Focused Examination:

- Requires limited examination of the affected body area or organ system. The documentation found examination of four systems: constitutional, musculoskeletal, psychiatric, and skin. This component was met.

The division concludes that the documentation does not sufficiently support the level of services billed for the date of service in dispute.

- The requestor billed CPT Code 97001-GP on January 15, 2013; the respondent denied this is using denial codes "247" – A payment or denial has already been recommended for this service; "B13" – Previously paid. Payment for this claim/service may have been provided in a previous payment; and "PI" – These are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not reasonable or necessary. Review of the documentation submitted finds that the carrier has not supported their denials; therefore, in accordance with 28 Texas Administrative Code 134.203(b), "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 and (c) 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 $55.30…" The MAR amount for this physical evaluation code is ((55.30 ÷ 34.023) x $73.88) is $120.08. The requestor is seeking $116.71; therefore $116.71 is recommended.
- CPT Code 76881 – Defined as "Ultrasound, extremity, nonvascular, real-time with image documentation; complete." The respondent denied the procedure using denial codes "309" – The charge for this procedure exceeds the fee schedule allowance; "828" – Chiropractic treatment exceeds 24 limitation for injuries occurring on or after January 1, 2004; "W1" – Workers Compensation State Fee Schedule adjustment and "QA" – The amount adjusted is due to bundling or unbundling of services." Review of the submitted documentation finds that the respondent has not supported the denial reasons. In accordance with 134.203(b)(1) which states in part, "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"; and (c)(1), which states in part, "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 $55.30…" The MAR amount for this ultrasound code is (55.30 ÷ 34.023) x 122.10) is $198.46. The requestor is seeking 197.80; therefore reimbursement in the amount of 197.80 is recommended.
- CPT Code 97140-GP (2 units) for dates of service January 28, 2013 through February 11, 2013 were denied by the respondent using denial codes "119" – Benefit Maximum for this time period or occurrence has been reached and "QA" – The amount adjusted is due to bundling or unbundling of services. The requestor obtained preauthorization for 10 Certified Units of the disputed procedure code; reference number L5ZX. Review of the documentation finds the respondent has not supported their denials. The preauthorization approval certified 10 units of manual therapy; however dates of service billed with CPT Code 97140-GP after February 11 have been denied for extent; therefore reimbursement is due as follows:
    - Procedure code 97140-GP, 2 units per day for service dates January 28, 2013 through February 11, 2013, represents professional services with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.43. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.979 is 0.43076. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.826 is 0.00826. The sum of 0.86902 is multiplied by the Division conversion factor of $55.30 for a MAR of $48.06. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 20% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $43.29 at 2 units is $86.58 times four dates of service equals a total of $346.32.

- CPT Code 97110-GP for dates of service January 28th through February 11, 2013 were denied using denial codes “119” – Benefit Maximum for this time period or occurrence has been reached; “QA” – The amount adjusted is due to bundling or unbundling of services; “247” – A payment or denial has already been recommended for this service and “B13” – Previously paid. Payment for this claim/service may have been provided in a previous payment. The requestor obtained preauthorization for 10 certified units of the disputed procedure code; preauthorization approval reference number is L5ZX. Review of the Explanation of Benefits finds that 2 units of this procedure code were paid on dates of service January 28, 2013 through February 12, 2013 for a total of 10 units reimbursed. Therefore, the requestor has been reimbursed according to the number of units that were preauthorized and no further reimbursement is due.
- CPT Code 97112-GP for dates of service February 18, 2013 through February 26, 2013 is not eligible for medical fee dispute resolution review as the dates of service have been denied for compensability, extent of injury or liability as discussed in paragraphs one and two above.
- CPT Code 97002-GP – defined as a Physical therapy re-evaluation was billed on February 26, 2013. The respondent denied the services using denial codes “11” – The diagnosis is inconsistent with the procedure and “QA” – The amount adjusted is due to bundling or unbundling of services. Review of the documentation finds this code is in CCI conflict with CPT Codes 97140, 97110 and 97112. Therefore, reimbursement per 28 Texas Administrative Code 134.203(b)(1) is not recommended.

4. The requestor billed CPT Code 99080-73 on date of service January 4, 2013 and again on February 14, 2013. The respondent denied reimbursement using denial codes “W1” – Workers Compensation State Fee Schedule Adjustment and “QA “– The amount adjusted is due to bundling or unbundling of services for date of service January 4, 2013 and “247” – A payment or denial has already been recommended for this service; “B13” – Previously paid. Payment for this claim/service may have been provided in a previous payment; and “PI” – These are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not reasonable or necessary for date of service February 14, 2013. Review of the information submitted finds the carrier has not supported their denials. Therefore, in accordance with 28 Texas Administrative Code 129.5(b), “The doctor shall file a Work Status Report in the form and manner prescribed by the Commission. (c) The doctor shall be considered to have filed a complete Work Status Report if the report is filed in the form and manner prescribed by the Commission, signed, and contains at minimum: (1) identification of the employee's work status; (2) effective dates and estimated expiration dates of current work status and restrictions (an expected expiration date is not binding and may be adjusted in future Work Status Reports, as appropriate, based on the condition and progress of the employee); (3) identification of any applicable activity restrictions; (4) an explanation of how the employee's workers' compensation injury prevents the employee from returning to work (if the doctor believes that the employee is prevented from returning to work); and (5) general information that identifies key information about the claim (as prescribed on the report). (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. (e) The Work Status Report filed as required by subsection (d) of this section shall be provided to the employee at the time of the examination and shall be sent, not later than the end of the second working day after the date of examination, to the carrier and the employer. (f) In addition to the requirements under subsection (d), the treating doctor shall file the Work Status Report with the carrier, employer, and employee within seven days of the day of receipt of: (1) functional job descriptions from the employer listing available modified duty positions that the employer is able to offer the employee as provided by §129.6(a) of this title (relating to Bona Fide Offers of Employment); or (2) a required medical examination doctor's Work Status Report that indicates that the employee can return to work with or without restrictions. (g) Filing the Work Status Report as required by subsection (f) of this section does not require a new examination of the employee. (h) The doctor shall file the Work Status Report as follows: (1) A report filed with the carrier or its agent shall be filed by facsimile or electronic transmission; (2) A report filed with the employer shall be filed by facsimile or electronic transmission if the doctor has been provided the employer's facsimile number or e-mail address; otherwise, the report shall be filed by personal delivery or mail; and (3) A report filed with the employee shall be hand delivered to the employee, unless the report is being filed pursuant to subsection (f) of this section and the doctor is not scheduled to see the employee by the due date to send the report. In this case, the doctor shall file the report with the employee by facsimile or electronic transmission if the doctor has been provided the employee's facsimile number or e-mail address; otherwise, the report shall be filed by mail. (i) 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;(2) CPT code "99080" with modifiers "73" and "RR" (for "requested report") shall be used when the doctor is billing for an additional report requested by or through the carrier under subsection (d)(3) of this section; and (3) CPT code "99080" with modifiers "73" and "EC" (for "extra copy") shall be used when the doctor is billing for an extra copy of a previously filed report requested by or through the carrier. (j) As provided in §126.6(f) of this title (relating to Order for Required Medical Examinations), a doctor who conducts a required medical examination (on anyone's behalf) in which the doctor determines that the employee can return to work immediately with or without restrictions, shall file the Work Status Report required by this section, but shall do so in accordance with the requirements of §126.6(f)."

Review of the Work Status Reports filed with this dispute finds that the Work Status Report dated January 4, 2013 meets the requirements of 28 Texas Administrative Code §129.5 and reimbursement in the amount of $15.00 is due.

Review of the Work Status Report dated February 14, 2013 finds reimbursement is not recommended in accordance with 28 Texas Administrative Code §129.5(d) "the doctor shall file the Work Status Report: (2) when the employee experiences a change in work status or a substantial change in activity restrictions" as there was no change in the activity restrictions from the previous work status report submission.

5. For the reasons stated above, the requestor has supported partial reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $675.83.

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 $675.83 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 9, 2014 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, effective May 31, 2012, *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 MDR 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.