



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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

SALVADOR P. BAYLAN, MD

Respondent Name

NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number

M4-14-2589-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

APRIL 21, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary.

Amount in Dispute: \$4,261.01

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 5, 2013 November 14, 2013 January 2, 2014 January 14, 2014 January 23, 2014	CPT Code 99213 Office Visit	\$130.00/each	\$549.49
November 14, 2013 January 7, 2014	CPT Code 97002 Physical Therapy Re-Evaluation	\$150.00/each	\$128.71
November 19, 2013 November 26, 2013 December 3, 2013 December 5, 2013 December 10, 2013 December 12, 2013 December 17, 2013	CPT Code 97014 Electric Stimulation	Not on Bill or EOB	\$0.00
November 19, 2013 December 19, 2013 January 14, 2014	CPT Code 97110-GP (X3) Therapeutic Procedure	\$195.00/each	\$370.41
November 21, 2013 November 26, 2013	CPT Code 97035-GP Ultrasoung	\$40.00/each	\$79.10

December 17, 2013 December 19, 2013 January 14, 2014			
November 21, 2013 November 26, 2013 December 3, 2013 December 5, 2013 December 10, 2013 December 12, 2013 December 17, 2013 January 2, 2014	CPT Code 97110-GP (X2) Therapeutic Procedure	\$130.00/each	\$693.65
December 10, 2013 December 12, 2013 January 9, 2014	CPT Code 97010-GP Hot or Cold Packs	\$35.00/each	\$27.53
January 2, 2014	CPT Code 97140-GP (X2) Manual Therapy Techniques	\$90.00	\$69.28
January 9, 2014	CPT Code 97110 (X4) Therapeutic Procedure	\$260.00	\$158.35
January 14, 2014	CPT Code G8553 Patient Referred for an Otologic Evaluation	\$0.01	\$0.00
January 14, 2014	CPT Code 99080-73 Work Status Report	\$15.00	\$0.00
February 28, 2014	CPT Code 99455-V4	\$300.00	\$0.00
March 28, 2014	CPT Code 99213 Office Visit	\$200.00	\$0.00
TOTAL		\$4,261.01	\$2,076.52

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 §134.600 requires preauthorization for physical therapy services.
3. 28 Texas Administrative Code §133.250, sets out the medical bill auditing process.
4. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets out medical fee guidelines for workers' compensation specific services.
5. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
6. 28 Texas Administrative Code §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - B5, 6478-Payment adjusted because coverage/program guidelines were not met or were exceeded.
8. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on April 29, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the

dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Issues

1. Does a preauthorization issue exist?
2. What is the reimbursement for CPT code 99213?
3. What is the reimbursement for CPT code 97002-GP
4. Is CPT code 97014 eligible for medical fee dispute resolution?
5. What is the reimbursement for physical therapy services?
6. Does the documentation support billing code 99080-73? Is the requestor entitled to reimbursement?
7. Does the documentation support billing code G8559? Is the requestor entitled to reimbursement?
8. Are dates of service February 28, 2014 and March 28, 2014 eligible for medical fee dispute resolution?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the disputed services rendered from November 5, 2013 through January 23, 2014 based upon reason codes "B5" and "6478."

28 Texas Administrative Code §134.600(p) states "Non-emergency health care requiring preauthorization includes: (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to: (i) Modalities, both supervised and constant attendance; (ii) Therapeutic procedures, excluding work hardening and work conditioning."

The requestor submitted the following copies of preauthorization reports:

- On November 15, 2013, the requestor obtained preauthorization approval for twelve (12) sessions of physical therapy beginning on November 11, 2013 and ending December 20, 2013.
- On November 18, 2013, the requestor obtained preauthorization approval for an initial physical therapy evaluation and twelve (12) sessions of physical therapy beginning on November 11, 2013 and ending December 20, 2013.
- On November 27, 2013, the requestor obtained preauthorization approval for twelve (12) sessions of physical therapy beginning on November 11, 2013 and ending January 15, 2014.

The Division reviewed the submitted documentation and finds that the requestor rendered twelve (12) sessions of physical therapy from November 19, 2013 through January 14, 2014. As noted above, the requestor obtained preauthorization for twelve sessions beginning November 11, 2013 and ending January 15, 2014; therefore, a preauthorization issue does not exist in this dispute and reimbursement is recommended per the Division's fee guideline.

2. 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 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."

The requestor is seeking dispute resolution for five (5) office visits coded 99213 rendered from November 5, 2013 through January 23, 2014. To determine the MAR the Division refers to 28 Texas Administrative Code §134.203(c)(1)(2).

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."

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 78212, which is located in San Antonio, Texas; therefore, the Medicare participating amount is based on locality "Rest of Texas".

The 2013 DWC conversion factor for this service is 55.3.

The 2013 Medicare Conversion Factor is 34.023.

The 2014 DWC conversion factor for this service is 52.83.

The 2014 Medicare Conversion Factor is 35.8228

Using the above formula the Division finds the following:

Dates of Service	Medicare Participating Amount	MAR	Insurance Carrier Paid	Amount Due
November 5, 2013 November 14, 2013	\$69.06	\$112.25 X 2 = \$224.50	\$0.00	\$224.50
January 2, 2014 January 14, 2014 January 23, 2014	\$69.61	\$108.33 X 3 = \$324.99	\$0.00	\$324.99

- The requestor billed for CPT code 97002-GP on November 14, 2013 and January 7, 2014.

CPT code 97002 is defined as "Physical therapy re-evaluation."

The 2013 and 2014 Medicare participating amount for code 97002 is \$40.17 and \$40.75, respectively.

Using the above formula, the Division finds that the following:

The 2013 and 2014 MAR are \$65.29 and \$63.42. The respondent paid \$0.00. As a result, reimbursement of \$128.71 is recommended.

- On the *Table of Disputed Services*, the requestor listed CPT code 97014 as a service in dispute from November 19, 2013 through December 17, 2013.

- 28 Texas Administrative Code §133.307 (c)(2)(J) a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions).” A review of the submitted medical bills finds that the requestor did not submit any bills that list CPT code 97014.
- 28 Texas Administrative Code §133.307 (c)(2)(K) a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB;” A review of the submitted EOBs finds that the requestor did not submit a copy of any EOBs that list CPT code 97014.
- 28 Texas Administrative Code §133.250(i) states “If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills).” The requestor did not submit any documentation to support New Hampshire Insurance Co. has received the medical bills in dispute, audited them, and taken final action for code 97014; therefore, the requestor has not supported that these services are eligible for medical fee dispute resolution. As a result, reimbursement is not recommended.

5. The following Table lists the physical therapy services in dispute and the Division’s Findings:

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.”

Date	Code	MAR	Insurance Carrier Paid	Amount Due
November 19, 2013 December 19, 2013 January 14, 2014	97110-GP (X3)	\$124.42 X 2 = \$248.84 \$121.57	\$0.00	\$370.41
November 21, 2013 November 26, 2013 December 17, 2013 December 19, 2013 January 14, 2014	97035-GP	\$15.84 X 4 = \$63.36 \$15.74	\$0.00	\$79.10
November 21, 2013 November 26, 2013 December 3, 2013 December 5, 2013 December 10, 2013 December 12, 2013 December 17, 2013 January 2, 2014	97110-GP (X2)	\$86.98 X 7 = \$608.86 \$84.79	\$0.00	\$693.65

January 2, 2014	97140-GP (X2)	\$69.28	\$0.00	\$69.28
January 9, 2014	97110-GP (X4)	\$158.35	\$0.00	\$158.35
December 10, 2013 December 12, 2013	97010-GP	\$9.31 X 2 = \$ \$18.62	\$0.00	\$27.53
January 9, 2014		\$8.91		

6. 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 submitted documentation finds that the requestor did not submit a copy of the work status report to support billing in accordance with 28 Texas Administrative Code §129.5 (d)(2); therefore, reimbursement cannot be recommended.

7. On January 14, 2014, the requestor billed \$0.01 for code G8553.

Code G8553 is defined as “Patient referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation.” Per Medicare policy, this service is not separately priced and is bundled to the office visit rendered on the same date. As a result, reimbursement is not recommended.

8. On February 28, 2014, the requestor billed CPT code 99455-V4 and code 99213 on March 28, 2014. A review of the submitted dispute packet finds the following:
- 28 Texas Administrative Code §133.307 (c)(2)(J) a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions).” A review of the submitted medical bills finds that the requestor did not submit a copy of any bills for dates of service February 28, 2014 and March 28, 2014.
 - 28 Texas Administrative Code §133.307 (c)(2)(K) a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB;” A review of the submitted EOBs finds that the requestor did not submit a copy of the EOBs for dates of service February 28, 2014 and March 28, 2014, nor convincing documentation providing evidence of insurance carrier receipt of the request for an EOB.

- 28 Texas Administrative Code §133.250(i) states “If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills).” The requestor did not submit any documentation to support New Hampshire Insurance Co. had received the medical bills in dispute, audited them, and taken final action; therefore, the requestor has not supported that the services in dispute are eligible for medical fee dispute resolution. As a result, reimbursement is not recommended.

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 \$2,076.52.

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 \$2,076.52 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature


Signature

Elizabeth Pickle, RHIA
Medical Fee Dispute Resolution Officer

8/13/2015
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.

