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 GARLAND

Respondent Name
FEDEX GROUND PACKAGE SYSTEM INC

MFDR Tracking Number
M4-14-2739-01

Carrier's Austin Representative
Box Number 22

MFDR Date Received
MAY 8, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: This claim was denied by the carrier as CASE MANAGEMENT TREATING DOCTOR. The employees that completed this visit are employees of the Elite Healthcare and not the treating doctor. Per TDI and rule 134.204(e) we have met the guidelines (SEE ATTACHED). The additional dates of service 06/24/13 and 06/26/2013 were denied based on timely filing. This claim was submitted within in the 95 days and was returned because of the treating doc on the claim for the PT Eval."

Amount in Dispute: $288.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "For dates of service 6-24-14 and 6-26-13 the bills were denied for timely filing. For date of service 2-12-14 we have sent this through to our medical bill review department to be processed with the modifier and previously this was left off the when it was processed."

Response Submitted By: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 12, 2014	CPT Code 99361-W1 Case Management Services	$113.00	$0.00
June 24, 2013	CPT Code 97002-GP	$69.18	$0.00
June 26, 2013	CPT Code 99213-25	$119.22	$0.00
June 26, 2013	CPT Code 99080-73 Work Status Report	$15.00	$0.00
TOTAL		$288.40	$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. 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. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
5. 28 Texas Administrative Code §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
6. 28 Texas Administrative Code §133.20, effective January 29, 2009, sets out the requirements for bill submission.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 663-022-Based on fee schedule guidelines, bills submitted after the 95th day after the date of service are disallowed.
   - B4-Late filing penalty.
   - W1-Workers compensation jurisdictional fee schedule adjustment.
   - No explanation of benefits were submitted for date of service June 26, 2013.

Issues

1. Did the requestor support billing the medical conference in accordance with 28 Texas Administrative Code §134.204? Is the requestor entitled to reimbursement?
2. Does the submitted documentation support billing of CPT code 97002-GP in accordance with 28 Texas Administrative Code §133.20(e)(2)?
3. Does a timely filing issue exist for CPT code 97002-GP? Is the requestor entitled to reimbursement?
4. Does the documentation support billing code 99213-25? Is the requestor entitled to reimbursement?
5. Does the documentation support billing code 99080-73? Is the requestor entitled to reimbursement?

Findings

1. The respondent paid $28.00 for the case management services, CPT code 99361, based upon reason codes "W1".

   28 Texas Administrative Code §134.204(e)(2) states: "Case Management Responsibilities by the Treating Doctor is as follows: Team conferences and telephone calls should be triggered by a documented change in the condition of the injured employee and performed for the purpose of coordination of medical treatment and/or return to work for the injured employee."

   28 Texas Administrative Code §134.204(e)(4) states "Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity. Case management services shall be billed and reimbursed as follows: (A) CPT Code 99361. (i) Reimbursement to the treating doctor shall be $113. Modifier "W1" shall be added. The requestor billed CPT code 99361-W1; however, the documentation does not support that the treating doctor participated in the case management service.

   Review of the submitted TEAM CONFERENCE report finds that the requestor listed the participants in the conference; however, the record does not support the treating doctor participated to support billing code 99361-W1 in accordance with 28 Texas Administrative Code §134.204(e)(4)(A)(i). The documentation also does not support that the case management services were triggered by a documented change in the condition of the injured employee and performed for the purpose of coordination of medical treatment and/or return to work for the injured employee. As a result, reimbursement is not recommended.

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."

   On June 24, 2013, the requestor billed CPT code 97002-GP.

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

- The requestor appended modifier “GP-Services delivered under an outpatient physical therapy plan of care.”

The requestor states that “When initially billed we billed with the incorrect OCT/PT. I have made the necessary corrections and attached all original documents for your review.”

28 Texas Administrative Code §133.20(e)(2) states “A medical bill must be submitted: in the name of the licensed health care provider that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care.” A review of the original bill indicates that Dr. Michael Adair billed CPT code 97002-GP; however, the Physical Therapy Evaluation report was signed by “SL Silvey, PT”. The Division finds that SL Silvey is a licensed physical therapist; therefore, the service should have been billed by the physical therapist.

The requestor indicated that they corrected the bill and resubmitted it to the respondent; however, the corrected bill was not submitted for review. Based upon the submitted documentation the requestor did not comply with 28 Texas Administrative Code §133.20(e)(2).

3. According to the explanation of benefits the respondent denied reimbursement for CPT code 97002-GP based upon reason codes “663-022”, and “B4”.

   28 Texas Administrative Code §133.20(g), states “Health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier.” The requestor indicated that they corrected and resubmitted the bill. Per 28 Texas Administrative Code §133.20(g), the corrected bill is a new bill.

   Texas Labor Code §408.027(a) states “A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment.” No evidence was submitted to support when the corrected bill was sent to the respondent timely. As a result, no reimbursement is recommended for code 97002-GP.

4. A review of the submitted documentation finds that neither party to the dispute submitted any explanation of benefits for date of service June 26, 2013; therefore, CPT code 99213-25 will be reviewed per Division rules and fee guideline.

   - 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 appended modifier “25-Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service.

   A review of the submitted medical reports finds that the requestor did not document 2 of the 3 key components for billing CPT code 99213. As a result, reimbursement is not recommended.

5. On February 26, 2013, the requestor billed CPT code 99080-73.

   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."

The requestor submitted the work status report that does not support a change in the claimant's work status or a substantial change in activity restrictions to support billing in accordance with 28 Texas Administrative Code §129.5 (d)(1) and(2); therefore, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	02/05/2015 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, 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.