



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
LOUIS F. PUIG, MD

Respondent Name
UNION TANK CAR CO & SUBSIDIARY

MFDR Tracking Number
M4-15-1104-01

Carrier's Austin Representative
Box Number 48

MFDR Date Received
DECEMBER 9, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We request a resolution based on the fact that the treatment and procedures provided to the patient were indeed furnished as well as documented."

Amount in Dispute: \$801.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "[Claimant] has two claims. The first injury occurred on 9/23/13 and the second injury occurred on 12/17/13. Although the DWC 60 shows the date of injury of 12/17/13, all the bills submitted by the provider were submitted under the 9/23/13 DOI. The CMS-1500's we rec'd list the DOI as 9/23/13 yet they were billing for services performed in December 2013 and January 2014. In addition, the supporting medical behind each bill rec'd was for services performed in September 2013. This is the reason the bills were denied.

In review of the DWC 60 the provider submitted, the bills appear to have been corrected with the correct DOI of 12/17/13 and the provider attached the medical specific to the date of service on the bill. However, we do not have any record of receiving the bills with the appropriate DOI and medical documentation prior to receipt of the DWC 60. I am going to escalate the bills submitted with the DWC 60 and ask our bill review vendor to process the bills, despite the fact that the bills were not timely filed, in order to resolve this dispute."

Response Submitted By: Gallagher Bassett

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. It lists two rows of services: one for December 17, 2013 (Office Visit) and another for December 17, 20, 23, and 27, 2013 (Work Status Report).

January 10, 2014			
December 17, 2013	CPT Code 12001 Surgical Repair Procedure	\$187.84	\$150.43
December 17, 2013	CPT Code 73130 Hand X-Ray	\$44.14	\$44.14
December 17, 2013	CPT Code 90703 Tetanus Shot	\$17.96	\$17.96
December 20, 2013 December 23, 2013 January 10, 2014	CPT Code 99213 Office Visit	\$75.83/ea	\$151.66
December 23, 2013	HCPCS Code L3999 Upper Limb Orthotic	\$49.00	\$0.00
December 27, 2013	CPT Code 99214 Office Visit	\$112.46	\$0.00
		\$801.66	\$394.19

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 §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
3. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets out medical fee guidelines for workers' compensation specific services.
4. 28 Texas Administrative Code §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
5. 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 TexReg 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care would be fair and reasonable.
6. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 112-Service not furnished directly to the patient and/or not documented.
 - 18-Duplicate claim/service.

Issues

1. Does the documentation support billing code 99202-25? Is the requestor entitled to reimbursement?
2. Does the documentation support billing code 99080-73? Is the requestor entitled to reimbursement?
3. Does the documentation support billing code 12001? Is the requestor entitled to reimbursement?
4. Does the documentation support billing code 73130? Is the requestor entitled to reimbursement?
5. Does the documentation support billing code 90703? Is the requestor entitled to reimbursement?
6. Does the documentation support billing code 99213? Is the requestor entitled to reimbursement?
7. Does the documentation support billing code L3999? Is the requestor entitled to reimbursement?
8. Does the documentation support billing code 99214? Is the requestor entitled to reimbursement?

Findings

1. 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 99202 is defined as “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.”

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” to code 99202.

A review of the submitted medical report does not support billed service, specifically, the requestor did not document an expanded problem focused history; therefore, reimbursement is not recommended.

2. The requestor billed CPT code 99080-73 on December 17, 2013, December 20, 2013, December 23, 2013, December 27, 2013 and January 10, 2014. The respondent denied reimbursement for code 99080-73 based upon reason code “112.”

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 Division reviewed the submitted work status reports and finds the following:

- The requestor filed the December 17, 2013 report in accordance with 28 Texas Administrative Code §129.5 (d)(1); therefore, reimbursement of \$15.00 is recommended.
- The requestor did not file the December 20, 2013, December 23, 2013 and January 10, 2014 reports in accordance with 28 Texas Administrative Code §129.5 (d)(2); therefore, reimbursement is not recommended.
- The requestor filed the December 27, 2013 report in accordance with 28 Texas Administrative Code §129.5 (d)(2); therefore, reimbursement of \$15.00 is recommended.

3. On December 17, 2013, the requestor billed CPT code 12001. The respondent denied reimbursement based upon reason code "112."

CPT code 12001 is defined as "Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less."

A review of the submitted report, supports billed service; therefore, reimbursement is recommended.

28 Texas Administrative Code §134.203(c)(1)(2), which states "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).

The 2013 DWC conversion factor for this service is 55.3.

The Medicare Conversion Factor is 34.023.

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77505 which is located in Pasadena, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for "Houston, Texas".

The Medicare participating amount is \$92.55.

Using the above formula, the Division finds the MAR is \$150.43. The respondent paid \$0.00, as a result reimbursement of \$150.43 is recommended.

4. On December 17, 2013, the requestor billed CPT code 73130. The respondent denied reimbursement based upon reason code "112."

CPT code 73130 is defined as "Radiologic examination, hand; minimum of 3 views."

A review of the submitted report, supports billed service; therefore, reimbursement is recommended.

The Medicare participating amount is 33.74.

Using the above formula, the MAR is \$54.84. The requestor is seeking a lesser amount of \$44.14. The respondent paid \$0.00, as a result, reimbursement of \$44.14 is recommended.

5. On December 17, 2013, the requestor billed CPT code 90703. The respondent denied reimbursement based upon reason code "112."

CPT code 90703 is defined as "Tetanus toxoid adsorbed, for intramuscular use."

A review of the submitted report, supports billed service; therefore, reimbursement is recommended.

CPT code 90703 does not have a relative value unit or payment set by Medicare.

28 Texas Administrative Code §134.203(f) states "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of

this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).

28 Texas Administrative Code §134.203(d)(1)(2) states “The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

(1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule.”

CPT code 90703 does not have a fee listed in DMEPOS fee schedule.

“(2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS.”

CPT code 90703 has a fee schedule of \$26.01; therefore the MAR is \$32.51. The requestor is seeking \$17.96. The respondent paid \$0.00; therefore, the requestor is due \$17.96.

6. On December 20, 2013, December 23, 2013 and January 10, 2014 the requestor billed CPT code 99213. The respondent denied reimbursement based upon reason code “112.”

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 reports, supports billed service on December 20 and 23, 2013; therefore, reimbursement is recommended.

A report for date of service January 10, 2014 was not submitted to support billed service; therefore, reimbursement is not recommended.

The Medicare participating amount is \$73.00.

Using the above formula the MAR is \$118.65. The requestor is seeking a lesser amount of \$75.83. The respondent paid \$0.00; therefore, the requestor is due \$75.83 X 2 dates = \$151.66.

7. On December 23, 2013, the requestor billed CPT code L3999. The respondent denied reimbursement based upon reason code “112.”

HCPCS code L3999 is defined as “Upper limb orthotic, not otherwise specified.”

A review of the submitted report, supports billed service; therefore, reimbursement is recommended.

28 Texas Administrative Code §134.203(d)(1-3) states “The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

(2) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule.”

HCPCS code L3999 does not have a fee listed in DMEPOS fee schedule.

“(2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS.”

HCPCS code L3999 does not have a fee listed in DMEPOS fee schedule.

“(3) which states “if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.”

28 Texas Administrative Code §134.203(f) states “For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).”

28 Texas Administrative Code §134.1, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(f) which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought of \$49.00 for HCPCS code L3999 would be a fair and reasonable rate of reimbursement. As a result payment cannot be recommended.

8. On December 27, 2013, the requestor billed CPT code 99214. The respondent denied reimbursement based upon reason code "112."

CPT code 99214 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: A detailed history; A detailed examination; Medical decision making of moderate complexity. 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 moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family."

A review of the submitted report does not support the level of service billed; therefore, 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 \$394.19.

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 \$394.19 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

07/09/2015
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.