



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

Gregory P Ennis

Respondent Name

Texas Mutual

MFDR Tracking Number

M4-15-3066-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

May 21, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "EcCare Health Centers states that the amount of \$728.72 is past due and that interest should be ordered in addition to the balance of this bill per rule 134.130 of TAC 28 part 2."

Amount in Dispute: \$728.72

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...Code 99442 is an E&M service consisting of a 11-20 minutes discussion with the patient, according to the definition of the code. Because of the inconsistency between the documentation and the billing code Texas Mutual declined to issue payment... The requestor billed code 99215 for an E&M service on 9/4/14. Texas Mutual declined to issue payment as the documentation does not meet the CPT criteria for the code. Texas Mutual paid the fee guideline amounts for codes 36415, 82306, and 80053. The requestor has not explained the reason for seeking reimbursement at billed charges instead of the fee guideline amounts. The requestor billed code 76499, an unlisted radiographic. However, there is no documentation from the requestor explaining what this is and its use on 9/4/14. For this reason Texas Mutual decline payment. The requestor billed code 99354 for a prolonged E&M service on 11/18/14. However, Texas Mutual has no billing from the requestor for the primary E&M code associated with 99354. Absent such, Texas Mutual declined to issue payment."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: August 9, 2014, 99442, \$728.72, \$0.00. Row 2: September 4, 2014, 99215, 36415, 99080, 82306, 80053, 73590, 76499, \$728.72, \$0.00. Row 3: November 18, 2014, 99354, \$728.72, \$0.00.

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 §133.20 sets out requirements for medical bill submission by health care providers.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. 28 Texas Administrative Code §129.5 sets out the reimbursement guidelines for work status reports.
5. 28 Texas Administrative Code §134.1 defines fair and reasonable guidelines.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 29 – The time limit for filing has expired
 - 150 – Payer deems the information submitted does not support this level of service
 - 714 – Accurate coding is essential for reimbursement, CPT/HCPCS billed incorrectly
 - 731 – Per 133.20(b) provider shall not submit a medical bill late that the 95th day after the date the service
 - 446 – This add-on code has been denied as the principal procedure was not billed
 - 790 – This charge was reimbursed in accordance to the Texas medical fee guideline
 - 248 – DWC-73 in excess of the filing requirements. No change in work status and/or restrictions; Reimbursement denied per Rule 129.5
 - 890 – Denied per AMA CPT code description for level of service and/or nature or presenting problems
 - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied the following disputed services with multiple claim adjustment reason codes;
 - Date of service August 9, 2014, submitted code 99442 – Denial code 29 – “The time limit for filing has expired.” Review of the submitted medical claim finds a signature date of May 18, 2015. 28 Texas Administrative Code §133.20 states in pertinent part, “(b) Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.” No documentation was found to support timely submission of the medical claim or any exceptions to Rule 408.0272 apply. The carrier's denial is supported.
 - Date of service September 4, 2014; Submitted code 99215 – Denial codes 150 – “Payer deems the information submitted does not support this level of service” and 890 – “Denied per AMA CPT code description for level of service and/or nature of presenting problems.” 28 Texas Administrative Code §134.203 (b) states, “(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;”

Review of the submitted code finds 99215 – “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 comprehensive history; A comprehensive examination; Medical decision making of high 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, 40 minutes are spent face-to-face with the patient and/or family.”

The submitted patient note dated September 4, 2014 documents;

- History of Present Illness (HPI) – Status of 1 chronic condition. Requirements of submitted code (3). Requirement not met

- History of Present Illness (HPI) – elements (2). Requirements of submitted code (4). Requirements not met.
- Review of symptoms – (none, questionnaire referenced but not included with dispute) Requirements of code – complete. Requirements of code not met.
- Examination – (1) each extremity. Requirements of code 8 or more systems. Requirements of code not met.
- Organ systems – (1) constitutional. As above.

Supporting documentation for use of submitted code was not found. The carrier’s denial is supported.

- Date of service September 4, 2014, submitted code 99080. Denial code 248 – DWC-73 in excess of the filing requirements. No change in work status and/or restrictions; Reimbursement denied per Rule 129.5.” 28 Texas Administrative Code §129.5 (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;...” Review of the submitted patient note finds, “There has been a slight improvement at this time.” No documentation of change in work status or substantial change in activity restrictions was found within submitted documentation. The carrier’s denial is supported.
- Date of service September 4, 2014, submitted codes 36415, 82306, 80053. Reduction code 790 – “This charge was reimbursed in accordance to the Texas medical fee guideline.” 28 Texas Administrative Code §134.203 (e) states, “The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and, (2) 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service.”

CMS payment policy files identify those clinical laboratory codes which contain a professional component, and those which are considered technical only. The codes in dispute are not identified by CMS as having a possible professional component, for that reason, the MAR is determined solely pursuant to 28 TAC §134.203(e)(1). The maximum allowable reimbursement (MAR) for the services in dispute is 125% of the fee listed for the codes in the 2014 Clinical Diagnostic Laboratory Fee Schedule found on the Centers for Medicare and Medicaid Services website at <http://www.cms.gov>.

Calculation of the MAR is as follows;

- 36415 – Fee schedule amount \$3.00 x 125% = \$3.75
- 82306 – Fee schedule amount \$37.07 x 125% = \$46.34
- 80053 – Fee schedule amount \$14.41 x 125% = \$18.01
- Total \$68.10

The carrier paid \$99.47 as shown on “Explanation of Benefits” dated December 5, 2014, for the services in dispute. No additional payment can be recommended.

- Date of service September 4, 2014, submitted code 76499. Denial code 97 – “The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.” Review of the code description finds, “Unlisted diagnostic radiographic procedure.” 28 Texas Administrative Code §134.203 (c) 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 (date of service yearly conversion factor).

Review of the CMS Physician Fee Schedule finds no allowable for this code. Therefore, per 28 Texas Administrative Code 134.203 (f) “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 (f) states, "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." As this code is not assigned a value by Medicare or Medicaid, being included in another procedure is not supported. However, additional reimbursement cannot be recommended as no documentation was found to support the submitted charge of the requestor as required by Rule 134.1.

- Date of service November 18, 2014, submitted code 99354. Review of the code description finds, "Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management service)." The carrier denied as 446 – "This add-on code has been denied as the principal procedure was not billed." 28 Texas Administrative Code §134.203 (b) states, "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;" CMS MedLearn Matters Article Number: SE1320, states in pertinent part, "An add-on code is a Health Care Common Procedure System (HCPCS) code or Current Procedural Terminology (CPT) code that describes a service that... ...is always performed in conjunction with another primary service. An add-on code is eligible for payment only if it is reported with an appropriate primary procedure performed by the same practitioner on the same date of service." Review of the submitted medical claim finds no other codes submitted on this date of service by the requestor. The carrier's denial is supported.
2. The Division has reviewed the applicable rules and fee guidelines as they relate to the submitted medical claim and the carrier's adjudication of the services in dispute. The carrier's denials and payments are supported. No additional payment can 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

July , 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.