



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

OrthoTexas Physicians and Surgeons

Respondent Name

Pacific Employers Insurance Company

MFDR Tracking Number

M4-16-0084-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

September 11, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the clearing house report DOS 10/9/2014 was billed 10/16/2014 and was confirmed accepted on 10/17/2014 which shows that this claim was process within the 95 days of timely format."

Amount in Dispute: \$190.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Without sufficient evidence to support proof of timely electronic bill submission to CorVel's clearinghouse on behalf of the insurance carrier it is assumed the electronic medical bill was only submitted to the health care provider's bill processing agent not later than the 95th day..."

CorVel received a paper medical bill for date of service 10/09/14 on 01/22/15 (105-days) which exceeds the 95-day statutory and regulatory requirements for timely filing."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 9, 2014	Evaluation & Management, established patient (99213) and Work Status Report (99080)	\$190.00	\$123.33

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 §129.5 sets out the procedures and fee guidelines for Work Status Reports.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for Division-specific services.
4. Texas Labor Code §408.027 sets out the procedures for payment of a health care provider.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 29 – Time limit for filing claim/bill has expired.
 - Note: “Effective 9/1/05, providers have 95 days to submit bills to the insurance carrier for reimbursement. Your bill exceeds this limit. Reimbursement is denied in accordance with Section 408.027 of the Act.”
 - 193 – Original payment decision maintained
 - RM2 – Time limit for filing claim has expired
 - Note: “Per rule 133.20 and section 408.027 of The Act, your documentation does not meet the criteria for proof of timely filing”

Issues

1. Are the insurance carrier’s denials of payment for the disputed services supported?
2. What is the MAR for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 29 – “Time Limit for Filing Claim/Bill has Expired.” Texas Labor Code §408.027 states that

A health care provider **shall submit** [emphasis added] 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.

Review of the submitted information finds that the Explanation of Review from CorVel, acting as the insurance carrier’s agent, lists the billing date as 01/12/2015. Further, the requestor provided documentation to confirm that a paper copy of the bill for the disputed services was **submitted** on January 12, 2015. The Division finds that January 12, 2015 is the 94th day after the date the services were provided to the injured employee. The insurance carrier’s denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. The dispute involves CPT code 99213, subject to the medical fee guidelines found in 28 Texas Administrative Code §134.203, and CPT code 99080-73, subject to the fee guidelines found in 28 Texas Administrative Code §129.5.

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 \$52.83...
- (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 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. The Division conversion factor for 2014 is \$55.75.

For CPT code 99213 on October 9, 2014, the relative value (RVU) for work of 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1.000 is 0.970000. The practice expense (PE) RVU of 1.00 multiplied by the PE GPCI of 0.916 is 0.916000. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.816 is 0.057120. The sum of 1.943120 is multiplied by the Division conversion factor of \$55.75 for a MAR of \$108.33.

28 Texas Administrative Code §129.5 (j) states, in relevant part,

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.

Therefore, the MAR for CPT code 99080-73 for date of service October 9, 2014 is \$15.00.

- 3. The total MAR for the disputed services is \$123.33. The insurance carrier paid \$0.00. A reimbursement of \$123.33 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$123.33.

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 \$123.33 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Laurie Garnes
Medical Fee Dispute Resolution Officer

October 6, 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.