



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

ZNAT INSURANCE CO

MFDR Tracking Number

M4-16-0881-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

DECEMBER 4, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the clearing house report DOS 5/7/2015 was billed electronically on 5/12/2015 & accepted by the payer on 5/14/2015. All of these dates fall within the 95 day timely filing deadline."

Amount in Dispute: \$275.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Zenith Insurance Company maintains its position that the bill was submitted 95 days after the date of service and no reimbursement is due."

Response Submitted by: Zenith Insurance Co.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Rows include May 7, 2015 with CPT Codes 99080-73 and 99214, and a TOTAL row.

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. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
2. 28 Texas Administrative Code §133.20, effective January 29, 2009, 34 Texas Register 430, sets out the procedure for healthcare providers submitting medical bills.
3. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
4. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for

professional services.

5. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets the reimbursement guidelines for the Division specific 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 services in dispute were reduced / denied by the respondent with the following reason codes:
  - 29-The time limit for filing has expired.
  - 200-Per 133.20, a medical bill shall not be submitted later than the 1<sup>st</sup> day of the 11<sup>th</sup> month (<08/31/05) or 95 days (>09/01/05) after DOS.
  - 350-Bill has been identified as a request for reconsideration or appeal.
  - W3-In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

### **Issues**

1. Did the requestor support position that the disputed bills were submitted timely?
2. Is the requestor entitled to reimbursement for code 99080-73?
3. Is the requestor entitled to reimbursement for code 99214?

### **Findings**

1. According to the explanation of benefits, the respondent denied reimbursement for the services in dispute based upon reason codes "29."

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."

28 Texas Administrative Code §102.4(h), states, "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."

The Division finds that the requestor submitted a copy of a report from Availity that support the bills was received by the carrier on May 14, 2015. This date is within the 95 day deadline to submit the bill to the respondent per Texas Labor Code §408.027(a); therefore, the respondent's denial is not supported.

2. On May 7, 2015, the requestor billed for work status report code 99080-73.

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 explanation of benefits finds the requestor documented a change in the claimant's work status to support billing code 99080-73 per 28 Texas Administrative Code §129.5(d)(2). As a result, reimbursement of \$15.00 is recommended.

3. 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 2015 DWC conversion factor for this service 56.2.

The Medicare Conversion Factor is 35.7547

Review of Box 32 on the CMS-1500 the services were rendered in zip code 75010, which is located in Carrollton, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for “Rest of Texas.”

The Medicare participating amount for code 99214 is \$104.13.

Using the above formula, the Division finds the MAR is \$163.67. The respondent paid \$0.00. As a result, reimbursement of \$163.67 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 \$178.67.

**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 \$178.67 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

12/29/2015  
\_\_\_\_\_  
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.**