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
CLINICS OF NORTH TEXAS

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-16-1802-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
FEBRUARY 26, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CNT has contacted Gallagher Bassett regarding the denial and are told the same denial reason that is on the EOB."

Amount in Dispute: $587.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 7, 2015	CPT Code 99203-25 Office Visit	$234.00	$163.25
	CPT Code 99080-73 Work Status Report	$15.00	$0.00
	HCPCS Code E0114 Crutches	$95.00	$0.00
	HCPCS Code L4350 Ankle Control Orthosis	$243.00	$102.85
TOTAL		$587.00	$266.10

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. 28 Texas Administrative Code §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16-Claim/service lacks information of has submission/billing error(s) which is needed for adjudication.
   - 4-The procedure code is inconsistent with the modifier used or a required modifier is missing.
   - W3- Additional payment made on appeal/reconsideration.
   - 193- Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
6. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on March 4, 2016. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Issues

1. Does the documentation support billing code 99203? 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 L4350? Is the requestor entitled to reimbursement?
4. Did the requestor support billing code E0114? Is the requestor entitled to reimbursement?

Findings

1. According to the submitted explanation of benefits, the respondent denied reimbursement for CPT code 99203-25 based upon reason code "16-Claim/service lacks information of has submission/billing error(s) which is needed for adjudication."

   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 99203 is defined as "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low 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 severity. Typically, 30 minutes are spent face-to-face with the patient and/or family."

   A review of the submitted medical report supports billing code 99203; therefore, reimbursement is recommended.

   Per 28 Texas Administrative Code §134.203(c)(1)(2), "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 is 56.2.

The Medicare Conversion Factor is 35.9335

Review of Box 32 on the CMS-1500 the services were rendered in zip code 76302, which is located in Wichita Falls, Texas; therefore, the Medicare participating amount is based on locality "Rest of Texas".

The Medicare participating amount for code 99203 is $104.38.

Using the above formula, the MAR is $163.25; this amount is recommended for reimbursement.

2. According to the submitted explanation of benefits, the respondent denied reimbursement for CPT code 99080-73 based upon reason code "16-Claim/service lacks information of has submission/billing error(s) which is needed for adjudication."

   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."

   A review of the submitted documentation finds the requestor did not submit a copy of the DWC-73 to support billing. As a result, reimbursement is not recommended.

3. According to the submitted explanation of benefits, the respondent denied reimbursement for HCPCS code L4350 based upon reason code "16-Claim/service lacks information of has submission/billing error(s) which is needed for adjudication."

   HCPCS code L4350 is defined as "Ankle control orthosis, stirrup style, rigid, includes any type interface (e.g., pneumatic, gel), prefabricated, off-the-shelf."

The requestor submitted a copy of a report that supports billing; therefore, reimbursement is recommended.

28 Texas Administrative Code §134.203(b)(1) 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; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

Per 2015 NCCI Policy Manual for Medicare Services, Chapter 1 (T) states, "The *CPT Manual* includes codes to identify services or procedures not described by other HCPCS/CPT codes. These unlisted procedure codes are generally identified as XXX99 or XXXX9 codes and are located at the end of each section or subsection of the manual. If a physician provides a service that is not accurately described by other HCPCS/CPT codes, the service should be reported utilizing an unlisted procedure code. A physician should not report a CPT code for a specific procedure if it does not accurately describe the service performed. It is inappropriate to report the best fit HCPCS/CPT code unless it accurately describes the service performed, and all components of the HCPCS/CPT code were performed. Since unlisted procedure codes may be reported for a very diverse group of services, the NCCI generally does not include edits with these codes."

Per 2015 NCCI Policy Manual for Medicare Services, Chapter 12(A) states,"The HCPCS Level II codes are alpha-numeric codes developed by the Centers for Medicare and Medicaid Services (CMS) as a complementary coding system to the *CPT Manual*. These codes describe physician and non-physician services not included in the *CPT Manual*, supplies, drugs, durable medical equipment, ambulance services, etc." HCPCS code L4350 is a HCPCS Level II code. Therefore, the guidelines outlined in 28 Texas Administrative Code §134.203(d)(1-3) apply to the disputed service.

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:

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

Per the DMEPOS fee schedule HCPCS code L4350 has a fee of $82.28.

Therefore, to determine the MAR $82.28 X 125% = $102.85. The respondent paid $0.00. As a result, $102.85 is recommended.

4. According to the explanation of benefits, the respondent denied reimbursement for HCPCS code E0114 based upon reason code "4-The procedure code is inconsistent with the modifier used or a required modifier is missing ."

HCPCS code E0114 is defined as "Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips, and handgrips."

A review of the submitted billing finds that the requestor did not append a modifier to code E0114 to indicate that the crutches were new, used or a rental. The DMEPOS fee schedule lists different reimbursements that are dependent on the modifier used. Because the requestor failed to use a modifier, the respondent's denial of reimbursement is supported. As a result, 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 $266.10.

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 $266.10 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		04/27/2016
Signature	Medical Fee Dispute Resolution Officer	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.