



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
EcCARE HEALTH CENTERS

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-16-3133-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
JUNE 14, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "EcCare does claim that a balance of \$686.25 is due along with interest as described in rule 134.130."

Amount in Dispute: \$686.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requester billed code 99214. Texas Mutual denied payment because the requestor's documentation does not meet the CPT criteria for 99214. The History is expanded problem focused, the Examination is expanded problem focused, and the Medical Decision making is straightforward. Texas Mutual declined to issue payment for the DWC73 as there was no change in work status from the previous DWC73. (Attachment) Texas Mutual denied payment of the orthotic device billed with L1843 as it requires preauthorization and there is no evidence preauthorization was sought or obtained."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Rows include November 19, 2015 with CPT Code 99214 Office Visit, CPT Code 99080-73 Work Status Report, HCPCS Code L1843 Knee Brace, 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. 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. 28 Texas Administrative Code §134.600, effective March 30, 2014 requires preauthorization for specific services.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CAC-150-Payer deems the information submitted does not support this level of service.
 - CAC-16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
 - CAC-197-Precertification/authorization/notification absent.
 - 890-Denied per AMA CPT code description for level of service and/or nature of presenting problems.
 - 930-Pre-authorization required, reimbursement denied.
 - CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.
 - 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.
 - 891-No additional payment after reconsideration.
 - CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
 - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Does the documentation support billing code 99214? Is the requestor entitled to reimbursement?
2. Does the documentation support billing code 99080-73? Is the requestor entitled to reimbursement?
3. Does a preauthorization issue exist for HCPCS code L1843? 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 99214 is defined as "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers 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. Physicians typically spend 25 minutes face-to-face with the patient and/or family."

A review of the submitted medical report does not support the documentation requirement which require the 2 of 3 key components for code 99214; therefore, reimbursement is not recommended.

2. 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 explanation of benefits finds the requestor did not support billing for the work status report in accordance with 28 Texas Administrative Code §129.5(d)(2). As a result, reimbursement is not recommended.

3. HCPCS code L1843 is described as "Knee orthosis (KO), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise."

A review of the submitted billing finds that the requestor billed HCPCS code L1843 at \$500.00.

The respondent denied reimbursement for HCPCS code L1843 due to a lack of preauthorization.

28 Texas Administrative Code §134.600(p)(9) requires preauthorization for "all durable medical equipment (DME) in excess of \$500 billed charges per item (either purchase or expected cumulative rental)."

The requestor did not submit any documentation to support preauthorization was obtained for HCPCS code L1843; therefore, a preauthorization issue exists in this dispute. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that 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

07/07/2016
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.