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
JESSE SCHNERINGER, DC

Respondent Name
BITCO GENERAL INSURANCE CORP

MFDR Tracking Number
M4-16-3231-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JUNE 22, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I have proof of timely filing in the form a fax conformation, which shows that the bills and records were submitted on 12/02/2015, please see included copy."

Requestor's Supplemental Position Summary: "They state the treatment was not pre-authorized. However, treatment was authorized by the insurance carriers pre-authorization agent Corvel on 09/21/2015, they approved 10 visits between 09/21/2015 to 12/21/2015. The treatment was provided to the left shoulder injury, which is a compensable body part. The patient had 10 visits of physical medicine, which is within the ODG Guidelines, which is the guidelines adopted by the state of Texas, please see ODG excerpt below."

Amount in Dispute: $1,279.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOBs. The provider failed to get preauthorization for treatments and services requiring same. Further, per CCH decision, the compensable injury does NOT extend to and include cervical sprain/strain, cervical osteophyte formation, thoracic sprain/strain, left elbow sprain/strain, bilateral knees, post-concussion syndrome, traumatic brain injury, seizure disorder, and acute psychosis. To the extent the disputed treatments are for these conditions, there a causal relation issues."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 14, 2015	CPT Code 99203-25 Office Visit	$125.00	$125.00
September 14, 2015	CPT Code 97140-59 Manual Mobilization Therapy	$50.00	$0.00
September 14, 2015	CPT Code 97110 (X2 Units) Therapeutic Procedure	$100.00	$0.00
September 14, 2015 September 21, 2015 September 23, 2015 October 5, 2015 October 7, 2015	CPT Code 97530 Therapeutic Activities	$50.00/ea	$0.00

October 9, 2015 October 12, 2015 October 14, 2015			
September 14, 2015 September 28, 2015	CPT Code 99080-73 Work Status Report	$15.00/ea	$0.00
September 16, 2015	CPT Code 99213-25 Office Visit	$84.00	$84.00
September 16, 2015	HCPCS Code E0730-NU TENS Unit	$450.00	$450.00
September 16, 2015	HCPCS Code A4595 Electric Stimulation Supplies	$40.00	$0.00
TOTAL		$1,279.00	$659.00

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 §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
3. 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.
4. 28 Texas Administrative Code §137.100, effective January 18, 2007, sets out the use of the treatment guidelines.
5. 28 Texas Administrative Code §134.203 set out the fee guideline s for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
6. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets out medical fee guidelines for workers' compensation specific services.
7. 28 Texas Administrative Code §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
8. The services in dispute were reduced / denied by the respondent with the following reason code:
   - 197-Payment adjusted for absence of precert/preauth.
   - 25-Separate E&M service, same physician.
   - 59-Distinct procedural service.
   - 97-Charge included in another charge or service.
   - NU-New Equipment.
   - R09-CCI; CPT Manual and CMS coding manual instructions.
   - 236-This proc or proc/mod combo not compatible w/another proc on same day.
   - P13-Payment reduced/denied based on state WC regs/policies.
   - 231-MUE procedures cannot be done in same day.
   - 29-The time limit for filing claim/bill has expired.
   - 73-Work status report.
   - FC-Functional capacity evaluations.
   - ODG-Services exceed ODG guidelines; preauth is required.
   - R88-CCI; Mutually exclusive procedures.
   - 16-Svc lacks info needed or has billing error(s).
   - W3-Appeal/Reconsideration.
   - P12-Workers' compensation state fee schedule adj.
   - 18-Duplicate claim/service.
   - R1-Duplicate billing.

Issues

1. Did the requestor support position that the disputed bills were submitted timely?
2. Does an extent of injury issue exist in this dispute?

3. Does the documentation support billing CPT code 99203-25 on September 14, 2015?
4. Did the physical therapy services rendered on September 14, 2015 require preauthorization? Is the requestor entitled to reimbursement?
5. Did HCPCS code E0730 rendered on September 16, 2015 require preauthorization? Is the requestor entitled to reimbursement?
6. Is the allowance of HCPCS code A4595 included in the allowance of another service rendered on the disputed date of service?
7. Is the allowance of CPT code 97530 included in the allowance of another service rendered on September 21, 2015 through October 14, 2015?
8. Does the documentation support billing CPT code 99080-73? Is the requestor entitled to reimbursement?
9. Does the documentation support billing CPT code 99213-25 on September 16, 2015?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the services in dispute based upon reason code "29-The time limit for filing claim/bill has expired."

   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 requestor submitted a copy of a "Fax Send Report" that supports on December 2 at 11:21 AM, the requestor submitted 69 pages to the respondent. The requestor noted that the 69 pages were bills and records. The division finds that the requestor sufficiently supports position that the disputed bills were submitted timely in accordance with Texas Labor Code §408.027(a).
2. The respondent states in the position summary that "per CCH decision, the compensable injury does NOT extend to and include cervical sprain/strain, cervical osteophyte formation, thoracic sprain/strain, left elbow sprain/strain, bilateral knees, post-concussion syndrome, traumatic brain injury, seizure disorder, and acute psychosis. To the extent the disputed treatments are for these conditions, there a causal relation issues." A review of the submitted explanation of benefits finds that the disputed services were not denied reimbursement based upon extent/causal relation issues.

   28 Texas Administrative Code §133.307(d)(2)(F) states "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section."

   No documentation was submitted that the extent/causal relation issue was presented to the requestor prior to the date of dispute resolution; therefore, this issue will not be addressed further.
3. On September 14, 2015, the requestor billed CPT code 99203-25.

   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."

   The requestor appended modifier "25-Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service."

   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."

A review of the submitted report supports billed service; therefore, reimbursement is recommended.

28 Texas Administrative Code §134.203(c)(1)(2) 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).

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77304 which is located in Conroe, Texas; therefore, the Medicare participating amount is based on locality "Rest of Texas".

The 2015 DWC conversion factor for this service is 56.2.

The 2015 Medicare Conversion Factor is 35.9335.

The 2015 Medicare participating amount is $104.38.

Using the above formula the MAR is $163.25 or less. The requestor is seeking $125.00; this amount is recommended for reimbursement.

4. According to the explanation of benefits, the respondent denied the physical therapy services rendered on September 14, 2015 due to a lack of preauthorization.

   The requestor submitted a supplemental response stating "They state that the treatment was not pre-authorized. However, treatment was authorized by the insurance carriers pre-authorization agent Corvel on 09/21/2015, they approved 10 visits." In support of the position, the requestor submitted a copy of the report dated September 21, 2015that authorized ten (10) sessions of physical therapy.

   Per 28 Texas Administrative Code §134.600(p)(5)(A) the non-emergency healthcare that requires preauthorization includes: "physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to:
   (i) Modalities, both supervised and constant attendance;
   (ii) Therapeutic procedures, excluding work hardening and work conditioning."

   Because the physical therapy services were rendered on September 14, 2015, this date is prior to the preauthorization approval.

   Per 28 Texas Administrative Code §134.600(p)(5)(C)(i) preauthorization for physical therapy services is required "except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following: (i) the date of injury." Date of service September 14, 2015, is past the first two weeks immediately following the date of injury.

   Based upon the submitted documentation, the division finds that the physical therapy services rendered on September 14, 2015, required preauthorization. As a result, reimbursement is not recommended.

5. The respondent also denied reimbursement for HCPCS code E0730-TENS unit rendered on September 16, 2015 based upon a lack of preauthorization.

Per 28 Texas Administrative Code §134.600(p)(9) preauthorization is required for "all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental)." The requestor billed $450.00; therefore, did not exceed the $500.00 threshold.

Per 28 Texas Administrative Code §134.600(p)(12) preauthorization is required for "treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits)." A review of the Shoulder Chapter in the ODG finds that a TENS unit is a recommended intervention for initial conservative treatment of acute shoulder symptoms; therefore, the TENS unit did not require preauthorization.

28 Texas Administrative Code §134.203(d)(1)(2) 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."

HCPCS code E0730 has a fee listed of $397.09 for this item rendered in Texas ; therefore, the MAR is $397.09 X 125% = $496.36. The requestor is seeking $450.00, this amount is recommended for reimbursement.

6. The respondent denied reimbursement for HCPCS code A4595 based upon reason code "97-Charge included in another charge or service."

   Per Medicare guidelines, Transmittal B-03-020, effective February 28, 2003 if Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) HCPCS codes are incidental to the physician service, it is not separately payable. A review of the submitted documentation finds that the requestor did not document the service or that it was a separate service to support billing HCPCS code A4595. As a result, reimbursement is not recommended.

7. The respondent denied reimbursement for physical therapy services, CPT code 97530, based upon "R88-CCI; Mutually exclusive procedures."

   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 HCPCS code S9088 does not have a relative value unit or payment; therefore, reimbursement for these services are set out in 28 Texas Administrative Code §134.203(f).

   On the disputed dates of service, the requestor billed codes 97530 and 97140. Per CCI edits, CPT code 97530 has a CCI conflict with code 97140. A modifier is allowed to differentiate the service. The requestor appended modifier "59-Distinct Procedural Service" to code 97140.

   Modifier "59" is defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

   A review of the submitted reports does not support a "different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual." The Division finds that the requestor has not supported the use of modifier "59." As a result, reimbursement is not recommended.

8. 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 September 14, 2015 report to support billed service. A review of the September 28, 2015 report does not support a change in work status to support billing; therefore, reimbursement is not recommended.

9. On September 16, 2015, the requestor billed CPT code 99213-25.

   CPT code 99213 is defined as "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and 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 low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family."

   The requestor appended modifier "25-Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service."

   A review of the submitted report supports billed service; therefore, reimbursement is recommended per 28 Texas Administrative Code §134.203(c)(1)(2).

   Using the above formula, the division finds the MAR for code 99213 is $109.51 or less. The requestor is seeking $84.00; this amount is recommended in reimbursement.

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 $659.00.

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 $659.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order

Authorized Signature

		01/06/2017
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.