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
ULTIMATE PAIN SOLUTIONS

Respondent Name
CITY OF HOUSTON

MFDR Tracking Number
M4-17-3307-01

Carrier's Austin Representative
Box Number 29

MFDR Date Received
July 13, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are the treating doctor and the diagnosis was confirmed by the Adjustor. There is no other doctor in this case. There is no dispute has been field on this case... This bill was fax to you on 04/17/2017 and after auditing and follow ups we resubmitted on 06/10/2017 with corrected modifier Fax confirmation available. Please address these issues..."

Amount in Dispute: $6,708.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the submitted documentation no additional recommendation for payment is being made at this time."

Response Submitted by: IMO

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
November 2, 2016 through April 10, 2017	97750-FC, 99080-73, 99213-25, 97545-WC and 97546-WC	$6,708.80	$0.00

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 §133.20 sets out the medical bill submission procedures for health care providers.
3. 28 Texas Administrative Code §102.4 establishes rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out the provisions related to payment of health care providers.
5. Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical claim.
6. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the workers' compensation specific services.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – The time limit for filing has expired
   - 222 – Charge exceeds Fee Schedule allowance
   - 402 – The appropriate modifier was not utilized
   - P12 – Workers compensation jurisdictional fee schedule adjustment

Issue(s)

1. What is the timely filing deadline applicable to dates of service November 2, 2017, November 16, 2016 and December 28, 2016?
2. Did the requestor meet the requirements of 28 Texas Administrative Code 133.307 (c)(2)(K) for date of service March 23, 2017?
3. Is the requestor entitled to additional reimbursement for the Work Conditioning services rendered on March 13, 2017 through April 5, 2017?
4. Did the insurance carrier issued payment for CPT Code 97750-FC rendered on February 4, 2017?
5. Did the insurance carrier issue payment for CPT Code 99080-73 rendered on March 6, 2017?
6. Did the insurance carrier issue payment for CPT Code 99213-25 rendered on January 21, 2017, March 6, 2017 and April 10, 2017?
7. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied the disputed services rendered on November 2, 2016, November 16, 2016 and December 28, 2016, with claim adjustment reason codes: "29 –The time limit for filing has expired."

   28 Texas Administrative Code §133.20(b) requires that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." Texas Labor Code §408.0272(b) provides that: Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if: (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with: (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured; (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title; or (2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

   The requestor submitted insufficient documentation to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the service(s) in this dispute. For that reason, the health care provider was required to submit the medical bill not later than 95 days after the date the disputed services were provided.

   Texas Labor Code §408.027(a) states that "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 that: "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."

   Review of the submitted information finds insufficient documentation to support that a medical bill was submitted within 95 days from the date the services were provided. Consequently, the requestor has forfeited the right to reimbursement due to untimely submission of the medical bill, pursuant to Texas Labor Code §408.027(a).

2. The requestor seeks reimbursement for CPT Code 99213-25 rendered on March 23, 2017, review of the documentation provided by the requestor did not contain an EOB for consideration in this dispute.

   Per 28 Texas Administrative Code 133.307 (c)(2)(K) states in pertinent part, "Requests. Requests for MFDR shall be filed in the form and manner prescribed by the division. Requestors shall file two legible copies of the request with the division (2) Health Care Provider or Pharmacy Processing Agent Request. The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include (K) a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB."

   As a result, the Division finds that date of service March 23, 2017 is not eligible for review.

3. The requestor seeks reimbursement for CPT Codes 97545-WC and 97546-WC rendered on March 13, 2017 through April 5, 2017.

   28 Texas Administrative Code §134.204 (h)(1)(B) states in pertinent part, "The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/ Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a Division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier. (1) Accreditation by the CARF is recommended, but not required. (B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."

   Review of the submitted documentation finds that the requestor billed CPT code 97545-WC and 97545-WC and did not appended modifier –CA to identify that the disputed services are CARF accredited, as a result, reimbursement is calculated per 28 Texas Administrative Code §134.204 (h)(1)(B).

   28 Texas Administrative Code §134.204(h) (2)(B) states in pertinent part, (h) The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/ Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/ Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a Division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier (2) For Division purposes, General Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Conditioning: (A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WC." Each additional hour shall be billed using CPT Code 97546 with modifier "WC." CARF accredited Programs shall add "CA" as a second modifier. (B) Reimbursement shall be $36 per hour. Units of less than one hour shall be prorated by 15-minute increments. A single 15-minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

Date of Service	Submitted Code	Submitted Charges	Units	20% MAR Reduction Non-CARF = $28.80/unit	Paid Amount	Amount Due
3/13/17	97545-WC	$310.00	2	$28.80 x 2 = $57.60	$57.60	$0.00
3/13/17	97546-WC	$165.00	1	$28.80 x 1 = $28.80	$28.80	$0.00
3/15/17	97545-WC	$310.00	2	$28.80 x 2 = $57.60	$57.60	$0.00
3/15/17	97546-WC	$165.00	1	$28.80 x 1 = $28.80	$28.80	$0.00
3/17/17	97545-WC	$310.00	2	$28.80 x 2 = $57.60	$57.60	$0.00
3/17/17	97546-WC	$165.00	1	$28.80 x 1 = $28.80	$28.80	$0.00
3/20/17	97545-WC	$310.00	2	$28.80 x 2 = $57.60	$57.60	$0.00
3/20/17	97546-WC	$165.00	1	$28.80 x 1 = $28.80	$28.80	$0.00
3/22/17	97545-WC	$310.00	2	$28.80 x 2 = $57.60	$57.60	$0.00
3/22/17	97546-WC	$165.00	1	$28.80 x 1 = $28.80	$28.80	$0.00
3/27/17	97545-WC	$310.00	2	$28.80 x 2 = $57.60	$57.60	$0.00
3/27/17	97546-WC	$165.00	1	$28.80 x 1 = $28.80	$28.80	$0.00
3/31/17	97545-WC	$310.00	2	$28.80 x 2 = $57.60	$57.60	$0.00
3/31/17	97546-WC	$165.00	1	$28.80 x 1 = $28.80	$28.80	$0.00
4/5/17	97545-WC	$310.00	2	$28.80 x 2 = $57.60	$57.60	$0.00
4/5/17	97546-WC	$165.00	1	$28.80 x 1 = $28.80	$28.80	$0.00
TOTAL		$3,800.00	24	$691.20	$691.20	$0.00

   The Division finds that the requestor was reimbursed according to the Medical Fee Guidelines, as a result, $0.00 additional is recommended.

4. The requestor seeks reimbursement for CPT Code 97750-FC x 16 units, rendered on February 4, 2017.

   Per 28 Texas Administrative Code §134.225, "The following applies to functional capacity evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a division ordered test; a maximum of two hours for an interim test; and a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required."

Per 28 Texas Administrative Code §134.203(c)(1) states, "(c) 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."

Procedure code 97750-FC, February 4, 2017, has a Work RVU of 0.45 multiplied by the Work GPCI of 1.02 is 0.459. The practice expense RVU of 0.46 multiplied by the PE GPCI of 1.009 is 0.46414. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.946 is 0.01892. The sum is 0.94206 multiplied by the DWC conversion factor of $57.50 for a MAR of $54.17. For each extra therapy unit after the first unit of the code with the highest PE, payment is reduced by 50% of the practice expense. This code has the highest PE for this date. The first unit is paid at $54.17. The PE reduced rate is $40.82 at 15 units is $612.30. The total is $666.47.

Review of the EOBs provided the by insurance carrier indicate that a payment in the amount of $866.72 was issued to the requestor, as a result, additional reimbursement for the disputed service cannot be recommended. The Division finds that the requestor is entitled to $0.00 for CPT Code 97750-FC rendered on February 4, 2017.

5. The requestor seeks reimbursement for CPT Code 99080-73 rendered on March 6, 2017.

   28 Texas Administrative Code §129.5 states in pertinent part, "(j) Notwithstanding any other provision of this title, a doctor or delegated physician assistant may bill for, and an insurance 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 insurance carrier, its agent, or the employer through its insurance carrier asks for an extra copy. The amount of reimbursement shall be $15. A doctor or delegated physician assistant 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 or delegated physician assistants are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors or delegated physician assistants 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 or delegated physician assistant is billing for a report required under subsections (e)(1), (e)(2), and (g) of this section."

   Review of the EOB submitted by the insurance carrier supports that a payment in the amount of $15.00 was issued to the requestor. As a result, additional reimbursement cannot be recommended.

6. The requestor seeks reimbursement for CPT Code 99213-25 rendered on January 21, 2017, March 6, 2017 and April 10, 2017.

   Per 28 Texas Administrative Code §134.203(c)(1) states, "(c) 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."

   - Procedure code 99213-25, rendered on January 21, 2017, has a Work RVU of 0.97 multiplied by the Work GPCI of 1.02 is 0.9894. The practice expense RVU of 1.02 multiplied by the PE GPCI of 1.009 is 1.02918. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.946 is 0.06622. The sum is 2.0848 multiplied by the DWC conversion factor of $57.50 for a MAR of $119.88. The insurance carrier issued a payment in the amount of $119.87, as a result, additional reimbursement is not recommended.
   - Procedure code 99213-25, rendered on March 6, 2017, has a Work RVU of 0.97 multiplied by the Work GPCI of 1.02 is 0.9894. The practice expense RVU of 1.02 multiplied by the PE GPCI of 1.009 is 1.02918. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.946 is 0.06622. The sum is 2.0848 multiplied by the DWC conversion factor of $57.50 for a MAR of $119.88. The insurance carrier issued a payment in the amount of $119.87, as a result, additional reimbursement is not recommended.
   - Procedure code 99213-25, rendered on April 10, 2017, has a Work RVU of 0.97 multiplied by the Work GPCI of 1.02 is 0.9894. The practice expense RVU of 1.02 multiplied by the PE GPCI of 1.009 is 1.02918. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.946 is 0.06622. The sum is 2.0848 multiplied by the DWC conversion factor of $57.50 for a MAR of $119.88. The insurance carrier issued a payment in the amount of $119.87, as a result, additional reimbursement is not recommended.

7. Review of the submitted documentation finds that the requestor is not entitled to additional reimbursement for the services in dispute. As a result, $0.00 is recommended.

Conclusion

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

		April 18, 2019
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, 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.