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
ADVANTAGE CLINIC, INC

Respondent Name
MID-CENTURY INSURANCE CO

MFDR Tracking Number
M4-18-1612-01

Carrier's Austin Representative
Box Number 14

MFDR Date Received
JANUARY 25, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier denied medical bills for dates of service 2/28/17 and 4/4/17 for reason not timely filing. Reconsiderations were filed with proof of timely filing with Availity EDI claim history report that shows claim was accepted by payer timely."

Amount in Dispute: $555.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier properly applied the Division's rules in this case and stands by the reasons for denials of payment set forth in its Explanation of Benefits."

Response Submitted By: Stone Loughlin Swanson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 28, 2017	CPT Code 99204	$320.00	$0.00
	CPT Code 99080-73	$50.00	$15.00
April 4, 2017	CPT Code 99213	$135.00	$0.00
	CPT Code 99080-73	$50.00	$0.00
TOTAL		$555.00	$15.00

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 §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional services.
4. 28 Texas Administrative Code §134.239, effective July 7, 2016, sets out medical fee guidelines for workers' compensation specific services.
5. 28 Texas Administrative Code §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
6. The services in dispute were reduced / denied by the respondent with the following reason code:
   - 29-The time limit for filing claim/bill has expired.
   - RM2-The time limit for filing claim has expired.
   - W3-Appeal/Reconsideration

Issues

1. Did the requestor support position that the disputed bills were submitted timely?
2. Does the documentation support billing CPT codes 99204 and 99213? Is the requestor entitled to reimbursement?
3. Does the documentation support billing code 99080-73? Is the requestor entitled to reimbursement?

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 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."

   The respondent wrote "Carrier properly applied the Division's rules in this case and stands by the reasons for denials of payment set forth in its Explanation of Benefits."

   The requestor submitted copies of reports from Availity that supports claim was sent to Farmers Insurance on April 13, 2017. The division finds that Farmers Insurance is a representative of Mid-Century Insurance; therefore, the division concludes that the requestor supported that the disputed bills were submitted timely.

2. The applicable fee guideline for the office visits is found at 28 Texas Administrative Code §134.203.

   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."

   The division reviewed the submitted documentation and finds:

   - On February 28, 2017, the requestor billed for an office visit with CPT code 99204. Code 99204 is described as "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate 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 to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family." A review of the submitted office visit report does not support the level of service billed specifically a comprehensive history and examination; therefore, the documentation does not support the required 3 key components for billing CPT code 99204. As a result, reimbursement is not recommended.

   - On April 4, 2017, the requestor billed for an office visit with CPT code 99213. 99213 is described 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." A review of the submitted report does not support the required 2 key components for billing CPT code 99213. As a result, reimbursement is not recommended.

3. 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 §134.239 states, "When billing for a work status report that is not conducted as a part of the examinations outlined in §134.240 and §134.250 of this title, refer to §129.5 of this title."

   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."

   Per 28 Texas Administrative Code §129.5(d)(1), the requestor is due reimbursement of $15.00 for the work status report dated February 28, 2017. The April 4, 2017 work status report does not support a substantial change in activity restrictions in accordance with 28 Texas Administrative Code §129.5(d)(2) to support billing. As a result, reimbursement is not recommended for this report.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement of $15.00 is due. As a result, the amount ordered is $15.00.

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 $15.00 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	05/10/2018 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.