TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name	**Respondent Name**
PROHEALTH MEDICAL GROUP	TEXAS MUTUAL INSURANCE COMPANY
MFDR Tracking Number	**Carrier's Austin Representative**
M4-20-1991-01	Box Number 54
MFDR Date Received	
April 7, 2020	

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I AM APPEALING FOR MEDICAL FEE DISPUTE THROUGH THE STATE OF TEXAS. THE ABOVE PATIENT WAS SEVERLY INJURED IN THE STATE OF TEXAS WHILE WORKING, BUT LIVES IN WISCONSIN. AFTER INITIAL TREATMENT AND BEING STABLIZED, THE PATIENT WAS TRANSPORTED BACK TO WISCONSIN FOR CONTINUED TREATMENT. THE ATTACHED OUTSTANDING BILLS, TEXAS MUTUAL IS FOLLOWING THEIR JURISDICTION. HOWEVER, I WAS TOLD BY THE STATE OF TEXAS REP, THAT ANY OUT OF STATE PROVIDERS, SHOULD NOT HA VE TO ABIDE BY THE TEXAS JURISDICTION BECAUSE IT IS NOT STATED IN THE POLICIES. I HAD ALREADY APPLEALED FOR PAYMENT ON PT SERVICES SINCE TEXAS MUTUAL DENIED FOR AUTH. MY APPEAL WAS REJECTED STATING NO RETRO AUTH COULD BE OBTAINED. SOME OF THE BILLS THAT DENIED TIMELY, WERE SUBMITTED TO THE PATIENTS GROUP HEAL TH CARRIER AND WERE TRANSFERRED AT A LATER DATE TO HIS WORK COMP ACCT. IN THE STATE OF WI, WE DO NOT HA VE TIMELY AND DO NOT NEED AUTH SERVICES. I DID NOT APPEAL ON ANYTHING OTHER THAN THE PT SERVICES AND ONCE THESE WERE DENIED, I KNEW ANYTHING ELSE I APPEALED WOULD BE REJECTED ALSO. ATTACHED ARE ALL OUTSTANDING BILLS AND DOCUMENTATION NEEDED IN ORDER TO REVIEW."

Amount in Dispute: $7,840.58

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider billed inaccurate cpt codes for DOS 5/30/2019, cpt code changed from 99211 to G0463. Corrected "new" bill was received on 10/29/2019, beyond 95 days from DOS. DOS 11/19/2019 was billed with 99244, this bill was denied for inaccurate coding as Medicare no longer recognizes 99244 as an office code. A corrected bill was not be submitted. DOS 4/13/2019 – cpt code 99232 was denied as untimely filing as the bill was received 2/17/2020, 95 days beyond DOS... A Memorandum of Authorization was issued to the provider for physical therapy treatment effective date 8/2/2019 through 9/25/2019. Physical Therapy services after 9/25/2019 was denied for no preauthorization. The provider did not request preauthorization or request a second extension for PT services via Memorandum of Authorization from Texas Mutual. Additional preauthorization or (Memorandum of Authorization) would be necessary as services were rendered in outpatient hospital facility. DOS 10/09/2019 – 10/25/2019. PROHEALTH CARE MEDICAL ASSOCIATION also provided return to work services noted cpt code 97545, the bills were denied for no preauthorization and missing appropriate modifier as indicated in Rule 134.230. 97545 must be billed with "WC" or "WH" modifier to specify the appropriate program. DOS 9/9/2019 – 11/05/2019. No payment due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
April 13, 2019 through November 19, 2019	97545-GO, 97545-HP, G0463, 99232, 99214, 99244, 97140-GP, 97530-GP-59, 97112-GP, and 97530-GP	$7,840.58	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 28 TAC §134.230, sets out the guidelines for return to work rehabilitation programs.
4. TLC §408.027 sets out the payment of health care providers.
5. TLC §408.0272 sets out certain exceptions for untimely submission of claim.
6. 28 TAC §133.20 sets out the rules for medical bill submission by health care provider.
7. 28 TAC §102.4 sets out the general rules for non-commission communications.
8. 28 TAC §134.203 sets out the medical fee guidelines for professional services.
9. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-29-THE TIME LIMIT FOR FILING HAS EXPIRED
   - 731-PER 133.20 (b) PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE OF SERVICE.
   - CAC-P12-WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 714-ACCURATE CPT/HCPCS, DATE OF SERVICE, UNITS, DAYS SUPPLY, MODIFIERS ARE ESSENTIAL FOR REIMBURSEMENT. SUBMIT CORRECTIONS WI 95 DAYS FROM DOS
   - CAC-W3-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 MII.INTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - CAC-197-PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
   - CAC-4-THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.
   - 350-IN ACCORDANCE WITH TDI-DWC RULE 134,804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL
   - 732-ACCURATE CODING IS ESSENTIAL FOR REIMBURSEMENT. MODIFIER BILLED INCORRECTLY OR MISSING. SERVICES ARE NOT REIMBURSABLE AS BILLED.
   - 891-NO ADDITTONAL PAYMENT AFTER RECONSIDERATION
   - 930-PRE-AUTHORIZATION REQUIRED; REIMBURSEMENT DENIED.

Issue(s)

1. Did the requestor submit a medical bill within the 95-day filing requirement for dates of service April 13, 2019, April 23, 2019, and May 30, 2019?
2. Is the insurance carrier's denial supported for CPT Code 99244 rendered on November 19, 2019?
3. Did the requestor submit a medical bill in accordance with 28 TAC §134.230 (2) and (3) for dates of service September 19, 2019 through October 8, 2019 and October 10, 2019 through November 5, 2019?
4. Did the requestor obtain preauthorization for CPT Code 97545 rendered on September 19, 2019 through October 8, 2019 and October 10, 2019 through November 5, 2019?
5. Did the requestor obtain preauthorization for CPT Codes 97140-GP and 97530-GP-59 rendered on October 9, 2019 and CPT Codes 97112-GP, 97530-GP and G0283-GP rendered on October 25, 2019?
6. Is the requestor entitled to reimbursement for the disputed services?

Findings

The requestor is a health care provider that rendered disputed services in the state of Wisconsin to an injured employee with an existing Texas Workers' Compensation claim. The health care provider was dissatisfied with the insurance carrier's final action. The health care provider requested reconsideration from the insurance carrier and was denied payment after reconsideration. The health care provider has requested medical fee dispute resolution under 28 TAC §133.307. Because the requestor has sought the administrative remedy outlined in 28 TAC §133.307 for resolution of the matter of the request for additional payment, the Division concludes that it has jurisdiction to decide the issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable rules.

1. The requestor seeks reimbursement for dates of service, April 13, 2019 - CPT Code 99232, April 23, 2019 - CPT Code 99214 and May 30, 2019 - HCPCS code G0463. The insurance carrier denied the disputed charge with denial reduction code "CAC-29-The time limit for filing has expired."

   The insurance carrier states, " The provider billed inaccurate cpt codes for DOS 5/30/2019, cpt code changed from 99211 to G0463. Corrected "new" bill was received on 10/29/2019, beyond 95 days from DOS… DOS 4/13/2019 – cpt code 99232 was denied as untimely filing as the bill was received 2/17/2020, 95 days beyond DOS."

   To determine if the disputed services are eligible for reimbursement the DWC refers to the following:

   TLC §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."

   TLC §408.0272(b)(1) states "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."

   28 TAC §133.20(b) states, "Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided…"

   28 TAC §133.20(g) states, "Health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier."

   28 TAC §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 DWC reviewed the documentation submitted by both parties and found the following:

   - The dates of service in dispute are April 13, 2019 - CPT Code 99232, April 23, 2019 - CPT Code 99214 and May 30, 2019 - HCPCS code G0463
   - HCPCS code G0463 and CPT Codes 99214 and 99232 were denied based upon time limit for filing claim had expired.
   - TLC §408.0272(b)(1) provides for the exception to timely filing based upon three scenarios noted above.

• The requestor did not support that the bill was sent to an insurer that meets one of the exceptions for timely filing.
• The requestor did not support that the claim was submitted to the respondent within the 95-day deadline set out in Texas Labor Code §408.027(a) and 28 TAC §133.20(b).
• The DWC finds that the respondent's denial of payment based upon timely filing is supported

2. The requestor seeks reimbursement for CPT Code 99244 rendered on November 19, 2019. The charge was denied by the insurance carrier with denial reduction code, "ACCURATE CPT/HCPCS, DATE OF SERVICE, UNITS, DAYS SUPPLY, MODIFIERS ARE ESSENTIAL FOR REIMBURSEMENT. SUBMIT CORRECTIONS WI 95 DAYS FROM DOS."

   The insurance carrier states, "DOS 11/19/2019 was billed with 99244, this bill was denied for inaccurate coding as Medicare no longer recognizes 99244 as an office code. A corrected bill was not be submitted

   28 TAC §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."

   MLN Matters Number: MM6740 states, "This article pertains to Change Request (CR) 6740, which alerts providers that effective January 1, 2010, the Current Procedural Terminology (CPT) consultation codes (ranges 99241-99245 and 99251-99255) are no longer recognized for Medicare Part B payment. Effective for services furnished on or after January 1, 2010, providers should code a patient evaluation and management visit with E/M codes that represents WHERE the visit occurs and that identify the COMPLEXITY of the visit performed. See the Key Points section of this article for details."

   The DWC finds that CPT Code 99244 is no longer recognized by Medicare. Medicare replaced the consultation codes with other appropriate E&M codes. As a result, the insurance carrier's denial reason is supported, and reimbursement cannot be recommended for the disputed service.

3. The requestor seeks reimbursement for CPT Code 97545-GO and 97545-HP rendered on September 19, 2019 through October 8, 2019 and October 10, 2019 through November 5, 2019.

   The insurance carrier denied the disputed services with denial reason codes, "732-Accurate coding is essential for reimbursement. Modifier billed incorrectly or missing. Services are not reimbursable as billed."

   The insurance carrier states, "PROHEALTH CARE MEDICAL ASSOCIATION also provided return to work services noted cpt code 97545, the bills were denied for no preauthorization and missing appropriate modifier as indicated in Rule 134.230. 97545 must be billed with "WC" or "WH" modifier to specify the appropriate program. DOS 9/9/2019 – 11/05/2019."

   28 TAC §134.230 states, "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 insurance carrier."

   28 TAC §134.230 states, "(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."

   28 TAC §134.230 states, "(3) For Division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening. (A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WH." Each additional hour shall be billed using CPT Code 97546 with modifier "WH." CARF accredited Programs shall add "CA" as a second modifier."

Provider billed CPT Codes 97545-GO and 97545-HP rendered on September 19, 2019 through October 8, 2019 and October 10, 2019 through November 5, 2019. The DWC finds that the medical bills submitted do not document that the provider billed with the appropriate modifier, "WH" for work hardening or "WC" for work conditioning. As a result, the DWC finds that the requestor has not billed in accordance with 28 TAC §134.230 (2) or (3). As a result, the insurance carrier's denial reason is supported, and reimbursement cannot be recommended for the disputed services.

4. The requestor seeks reimbursement for CPT Code 97545 rendered on September 19, 2019 through October 8, 2019 and October 10, 2019 through November 5, 2019. The insurance carrier denied the disputed service with denial reduction "930-Pre-authorization required; reimbursement denied."

   The insurance carrier states, "PROHEALTH CARE MEDICAL ASSOCIATION also provided return to work services noted cpt code 97545, the bills were denied for no preauthorization and missing appropriate modifier as indicated in Rule 134.230. 97545 must be billed with "WC" or "WH" modifier to specify the appropriate program. DOS 9/9/2019 – 11/05/2019."

   28 TAC §134.600 (p)(4)states, "(p) Non-emergency health care requiring preauthorization includes…(4) all work hardening or work conditioning services…"

   Review of the documentation submitted by both parties, does not support that the disputed services were preauthorized as required per 28 TAC §134.600 (p)(4), as a result, reimbursement cannot be recommended for the disputed services.

5. The requestor seeks reimbursement for CPT Codes 97140-GP and 97530-GP-59 rendered on October 9, 2019 and CPT Codes 97112-GP, 97530-GP and G0283-GP rendered on October 25, 2019.

   The insurance carrier denied the disputed services with denial reduction codes, "CAC-197-Precertification/ authorization/notification absent" and "930-Pre-authorization required, reimbursement denied."

   The insurance carrier states, "A Memorandum of Authorization was issued to the provider for physical therapy treatment effective date 8/2/2019 through 9/25/2019. Physical Therapy services after 9/25/2019 was denied for no preauthorization. The provider did not request preauthorization or request a second extension for PT services via Memorandum of Authorization from Texas Mutual. Additional preauthorization or (Memorandum of Authorization) would be necessary as services were rendered in outpatient hospital facility. DOS 10/09/2019 – 10/25/2019."

   Per 28 TAC §134.600 "(p) Non-emergency health care requiring preauthorization includes: (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels."

   Review of the submitted documentation does not support that the requestor obtained preauthorization for disputed dates of service, October 9, 2019, and October 25, 2019, as a result, reimbursement cannot be recommended.

6. Review of the submitted documentation finds that the requestor is not entitled to reimbursement for the disputed services. As a result, the amount ordered is $0.00.

Conclusion

For the reasons stated above, the DWC 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 TLC §413.031, the DWC has determined that the requestor is not entitled to reimbursement for the disputed services.

Authorized Signature

______________________	______________________	September 18, 2020
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 TAC §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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed, or personally delivered to the DWC 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 DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.