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
GASTROENTEROLOGY ASSOCIATES

Respondent Name
AMERICAN INTERSATE INSURANCE CO

MFDR Tracking Number
M4-21-0735-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
DECEMBER 28, 2020

REQUESTOR'S POSITION SUMMARY

"Attached you fill find claims and the notes for the hospital visits and the face sheet from the hospital stating where we need to bill the workers cop. I have been informed that was the wrong address and when we tried to explain to the case workers the case was still denied."

Amount in Dispute: $600.86

RESPONDENT'S POSITION SUMMARY

"In accordance with Sec. 408.0272(b)(1) the provider forfeited their right to reimbursement for this bill since they failed to submit the claim to the correct workers' compensation insurance carrier within 95 days after the provider was notified of the provider's erroneous submission of the claim."

Response Submitted By: Amerisafe Risk Service Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 1, 2020	CPT Code 99253	$399.65	$0.00
July 2, 2020	CPT Code 99232	$201.21	$116.91
TOTAL		$600.86	$116.91

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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective May 31, 2012, sets out the procedures for resolving

medical fee disputes.

2. Texas Labor Code (TLC) §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
3. TLC §408.0272, effective September 1, 2007, provides for exceptions for timely submission of a claim by a health care provider.
4. 28 TAC §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
5. 28 TAC §133.20, effective January 29, 2009, sets out the health care providers billing procedures.
6. The services in dispute were reduced / denied by the respondent with the following reason codes:
   - P12-Workers' compensation jurisdiction fee schedule adjustment.
   - Bills are not payable if the number of days between the date of service/discharge and the submission date exceeds 95 days.
   - The time limit for filing has expired.
   - The reductions was made for reasons indicated in note below or on the attached note or letter.
   - W3-No additional reimbursement allowed after review of appeal/reconsideration.

Issues

Is the requestor entitled to reimbursement for CPT codes 99253 and 99232 rendered on July 1 and 2, 2020?

Findings

1. The requestor provided consultation and hospital care services in the state of Tennessee on July 1 and 2, 2020 to an injured employee with an existing Texas Workers' Compensation claim. The requestor was dissatisfied with the respondent's final action. The requestor filed for reconsideration and was denied payment after reconsideration. The requestor filed for dispute resolution under 28 TAC §133.307. The DWC concludes that because the requestor sought the administrative remedy outlined in 28 TAC §133.307 for resolution of the matter of the request for additional payment, the dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules.
2. The requestor is seeking payment of $600.86 for CPT codes 99253 and 99232 rendered on July 1 and 2, 2020.
3. The respondent denied reimbursement for the disputed service based upon "The time limit for filing has expired."
4. To determine if the disputed services are eligible for reimbursement the DWC refers to the following statute:
   - 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."
   - TLC §408.0272(b)(2) 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: (2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider."
   - 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. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied. The medical bill submitted by the health care provider to the correct workers' compensation insurance carrier is subject to the billing, review, and dispute processes established by Chapter 133, including §133.307(c)(2)(A) - (H) of this title (relating to MDR of Fee Disputes), which establishes the generally acceptable standards for documentation."

5. The dispute was filed to TDI-DWC MFDR on December 28, 2020. TDI-DWC addresses the issue as follows:
   - On March 13, 2020, Governor Greg Abbott issued a proclamation declaring that Covid-19 was a statewide public health disaster. The declaration states in pertinent part, "Pursuant to Section 418.016 of the code, any regulatory statute prescribing the procedures for conduct of state business or any order of rule of a state agency that would in any way prevent, hinder, or delay necessary action in coping with this disaster shall be suspended upon written approval of the Office of the Governor. However, to the extent that the enforcement of any state statute or administrative rule regarding contracting or procurement would impede any state agency's emergency response that is necessary to cope with this declared disaster, I hereby suspend such statutes and rules for the duration of this declared disaster for that limited purpose."
   - The Texas Department of Insurance issued Commissioner's Bulletins# B-0010-20 as a result of the Governor's Proclamation. The bulletin is in effect for the duration of the governor's Covid-19 declaration, or until further notice from DWC. The bulletin notified the system participants that "Tolling of medical billing deadlines: Failure to submit a timely medical bill will be deemed an exception due to a catastrophic event under Labor Code Section 408.0272(b)(2)."

   MFDR's obligation under the Governor's Proclamations and the Commission's Bulletin is to accept dates of service July 1 and 2, 2020, as timely because the 95 day deadline, in this case, is tolled.

6. The requestor billed CPT code 99253 for a hospital consultation. Per CMS's Medical Learning Network (MLN) Matters, Change Request number 6740, effective January 1, 2010, "consultation codes (ranges 99241-99245 and 99251-99255) are no longer recognized for Medicare part B payment."

   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."

   28 TAC §134.203(a)(8) states, "Whenever a component of the Medicare program is revised, use of the revised component shall be required for compliance with Division rules, decisions, and orders for professional services rendered on or after the effective date, or after the effective date or the adoption date of the revised component, whichever is later."

   28 TAC §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."

   The DWC finds that CMS does not recognize CPT code 99253; therefore, per 28 TAC §134.203, the DWC adopted CMS policy regarding CPT code 99253. As a result, no reimbursement is recommended for this code.

7. 28 TAC §134.203(c)(1) 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."

   28 TAC §134.203(c)(2) states "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 Medicare Payment = Maximum Allowable Reimbursement (MAR).

   Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 37620 which is located in Tennessee; therefore, the Medicare locality is "Tennessee."

   The Medicare participating amount for CPT code 29822 at this locality is $69.95.

   The DWC conversion factor for 2020 is 60.32.

The Medicare conversion factor for 2020 is 36.0896.

Using the above formula, the MAR is $116.91. The respondent paid $0.00. The difference between MAR and amount paid is $116.91; this amount is recommended for reimbursement.

Conclusion

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the DWC has determined that the requestor is entitled to $116.91 reimbursement for the disputed services.

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 $116.91 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

______________________	______________________	02/02/2021
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 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 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 DWC. **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.