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
PATIENTS CHOICE FAMILY MEDICINE

Respondent Name
ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number
M4-21-2041-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JULY 13, 2021

REQUESTOR'S POSITION SUMMARY

"Our office feels these are invalid denials due to the fact that we submitted the original claim within 95 days from the service."

Amount in Dispute: $3,553.000

RESPONDENT'S POSITION SUMMARY

"If the provider is entitled to reimbursement and if it is for an 8 hour period the reimbursement at the most would be $800.00. The provider has also billed beyond the Medical Fee Guidelines under CPT code 99214 and 99080."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 30, 2020	CPT Code 97799-CP-GP (8 hours)	$3,160.00	$800.00
March 2, 2021	CPT Code 99214	$320.00	$231.51
	CPT code 99080-73	$73.00	$15.00
TOTAL		$3,553.00	$1,046.51

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 §408.027, effective September 1, 2007, sets out the rules for timely submission of

a claim by a health care provider.

3. 28 TAC §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
4. 28 TAC §133.20, effective January 29, 2009, sets out the health care providers billing procedures.
5. 28 TAC §134.230, effective July 17, 2016 sets out the reimbursement guidelines for return to work rehabilitation programs.
6. 28 TAC §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
7. 28 TAC §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
8. The services in dispute were reduced or denied payment based upon claim adjustment reason code(s):
    - P12-Workers' compensation jurisdictional fee schedule adjustment.
    - 29-The time limit for filing has expired.
    - 309-The charge for this procedure exceeds the fee schedule allowance.
    - 18-Exact duplicate claim/service.
    - 308-Billing is a duplicate of other services performed on same day.
    - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor entitled to reimbursement for chronic pain management program (CPT code 9779-CP) rendered on October 30, 2020, and Office visit (CPT code 99214) and work status report (CPT code 99080-73) rendered on March 2, 2021?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $3,553.00 for chronic pain management program **(**CPT code 9779-CP) rendered on October 30, 2020, and Office visit (CPT code 99214) and work status report (CPT code 99080-73) rendered on March 2, 2021.

2. The respondent denied reimbursement for the disputed chronic pain management program, office visit and work status report based upon timely filing.

3. 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."

    - 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."

    - 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."

4. Both parties to this dispute submitted documentation for consideration in support of their position. The DWC reviewed all the documentation and finds:

   - The dates of service in dispute are CPT codes 97799, 99214 and 99080-73.
   - The requestor submitted a fax confirmation report that supports the bill for date of service October 30, 2020 was sent of January 21, 2021. This date is within the 95 day deadline; therefore, the respondent's denial of payment for CPT code 97799 is not supported.
   - The requestor submitted an Explanation of Benefits for CPT codes 99214 and 99080 that lists "Check Date 04-28-21." This date is within the 95 day deadline; therefore, the respondent's denial of payment for CPT codes 99214 and 99080-73 is not supported.

5. The fee guideline for chronic pain management services is found in 28 TAC §134.230.

   28 TAC §134.230(1) states "Accreditation by the CARF is recommended, but not required. (A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the maximum allowable reimbursement (MAR). (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."

   The requestor billed 97799-CP-GP; therefore, the disputed program is non-CARF accredited and reimbursement shall be 80% of the MAR.

   28 TAC §134.230(5) states, "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs. (A) Program shall be billed and reimbursed using CPT code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited programs shall add "CA" as a second modifier. (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 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."

   The requestor billed for 8 hours; therefore, 80% of $125.00 = $100.00 X 8 hours = $800.00. The respondent paid $00.00. The requestor is due $800.00.

6. The fee guidelines for CPT code 99214 is found at 28 TAC §134.203.

   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(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).

- The DWC conversion factor for 2021 is 61.17.
- The Medicare conversion factor for 2021 is 34.8931.
- Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 75080 which is located in Richardson, Texas; therefore, the Medicare locality is “Dallas, Texas.”
- The Medicare participating amount for CPT code 99214 at this locality is $132.06

Using the above formula, the MAR is $231.51. The respondent paid $0.00. The difference between MAR and amount paid is $231.51.

7. 28 TAC §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 TAC §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 TAC §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.”

   The DWC finds the requestor is due $15.00 for the work status report.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $1,046.51.

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 DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of $1,046.51 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	08/12/2021 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.