TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Dr. Mario Pena, JR

Respondent Name
University Medical Center Health System

MFDR Tracking Number
M4-21-1908-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
September 20, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 14, 2020	CPT Code 72100-TC	$60.00	$42.69
	CPT Code 99214	$185.00	$177.89
	CPT Code 99080-73	$15.00	$15.00
	Total	$260.00	$235.58

Requestor's Position

"Enclosed is a print out of first notice from the patient on 05/05/2021 indicating this was workers' compensation. We have 95 days from 05/05/2021 to file the bill timely (see Coded Notes)."

Amount in Dispute: $260.00

Respondent's Position

The Austin carrier representative for University Medical Center Health System is Downs Stanford, PC. Downs Stanford, PC received a copy of this medical fee dispute on September 28, 2021. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information

As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

Findings and Decision

Authority

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

Statutes and Rules

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
3. TLC §408.0272 provides for exceptions for timely submission of a claim by a health care provider.
4. 28 TAC §102.4(h) sets out rules to determine when written documentation was sent.
5. 28 TAC §134.203 sets out the reimbursement guidelines for professional services.
6. 28 TAC §134.239 sets out medical fee guidelines for workers' compensation specific services.
7. 28 TAC §129.5 sets out the procedure for reporting and billing work status reports.

Denial Reasons

The insurance carrier [reduced or denied] the payment for the disputed services with the following claim adjustment codes:

- 29-The time limit for filing has expired.
- 731-Per Rule 133.20(B) providers shall not submit a medical bill later than the 95th day after the date the service.
- 69-Professional fees removed from charges.
- 4271-Per TX Labor Code Sec 408.027. Providers must submit bills to payors within 95 days of the date of service.
- P12-Workers' compensation jurisdictional fee schedule adjustment.
- 309-The charge for this procedure exceeds the fee schedule allowance.
- 289-The recommended allowance is based on the value for the technical component of the service performed.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is University Medical Center Health System's denial based on 29 supported?

2. Is Dr. Mario Pena entitled to reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $260.00 for CPT codes 72100-TC, 99214, and 99080-73 rendered on December 14, 2020.

   The respondent denied reimbursement for the disputed services based upon "29-The time limit for filing has expired."

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

   - 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. 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 §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."

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

- The date of service in dispute is December 14,2020.
- The disputed services were denied reimbursement based upon time limit for filing claim had expired.
- The requestor originally billed and was paid by Blue Cross and Blue Shield (BCBS) for the disputed services.
- TLC §408.0272(b)(1) provides for the exception to timely filing based upon three scenarios noted above.
- The requestor supported position that the bill was sent to an insurer that meets one of the exceptions for timely filing.
- The requestor was notified that erroneously billed BCBS and that the services were for a workers' compensation injury on May 5, 2021.
- The respondent received the bill on July 13, 2021. This date is within 95 days from being notified of the workers' compensation injury.
- The requestor supported position 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 respondent's denial of payment based upon timely filing is not supported.

2. Per 28 Texas Administrative Code §134.203(c)(1)(2), "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.

(2) 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 DWC had been using this MEI annual percentage adjustment: The 2006 DWC 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) DWC 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 2020 DWC Conversion Factor is 60.32

The 2020 Medicare Conversion Factor is 36.0896

The services were rendered in Lubbock, Texas; therefore, the locality is "Rest of Texas".

Using the above formula, the DWC finds the MAR is:

Code	Medicare Payment	MAR or §134.203 (h) Lesser of MAR billed amount	Insurance Carrier Paid	Amount Due
99214	$106.43	$177.89	$0.00	$177.89
72100-TC	$25.54	$42.69	$0.00	$42.69
			Total Allowable Reimbursement	$220.58

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 requestor billed CPT code 99080-73 for the work status report. The MAR for CPT code 99080-73 is $15.00; this amount is recommended for reimbursement.

The total allowable for the disputed services per the DWC fee guideline is $235.58. The insurance carrier paid $0.00. The requestor is due the difference between the total allowable and paid of $235.58.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that reimbursement of $235.58 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that University Medical Center Health System must remit to Dr. Mario Pena, JJR $235.58 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.}

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	12/28/2021 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.