TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

# Medical Fee Dispute Resolution Findings and Decision

## General Information

**Requestor Name**
James A. Mitchell, DC

**Respondent Name**
New Hampshire Insurance Co.

**MFDR Tracking Number**
M4-22-0148-01

**Carrier's Austin Representative**
Box Number 19

**DWC Date Received**
September 23, 2021

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| February 18, 2021 | CPT Code 99214 | $231.51 | $231.51 |
| March 31, 2021<br>April 28, 2021<br>May 26, 2021 | CPT Code 99213 | $43.93<br>$163.14<br>$163.14 | $370.21 |
| May 26, 2021 | CPT Code 99080 | $15.00 | $0.00 |
| | **Total** | $616.72 | $601.72 |

## Requestor's Position

"All necessary and supporting documentation is included with this reconsideration to properly justify/support the administered treatment still needing to be paid."

**Amount in Dispute:** $616.72

## Respondent's Position

The Austin carrier representative for New Hampshire Insurance Co is Flahive, Ogden & Latson. Flahive, Ogden & Latson 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, (TAC), §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code, (TLC), §408.027 sets out the rules for timely submission of a claim by a health care provider.
3. 28 TAC §133.20 sets out the rule for medical bill submission.
4. 28 TAC §134.239 sets out medical fee guidelines for workers' compensation specific services.
5. 28 TAC §129.5 sets out the procedure for reporting and billing work status reports.
6. 28 TAC §134.203 sets out the fee guidelines for professional services.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

February 18, 2021:

- P12-Workers' compensation fee schedule adjustment.
- 150, 00168-Payment adjustment because the payer deems the information submitted does not support this level of service.
- 309-The charge for this procedure exceeds the fee schedule allowance.
- 5721-To avoid duplicate bill denial for all reconsiderations/adjustments/additional payment requests submit a copy of this EOR or clear notation.

- 90202, B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.
- 247-A payment or denial has already been recommended for this service.

March 31, 2021:

- P12, 00223- Workers' compensation jurisdictional fee schedule adjustment.
- 4063-Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting.

April 28, 2021:

- 150-Payment adjusted because the payer deems the information submitted does not support this level of service.
- 5352-Service reduced/denied as level of E&M code submitted is not supported by documentation.
- 6281-After review of the bill and the medical record this service is best described by 99212. Submitted documentation did not meet at least 2 of
- 5721-To avoid duplicate bill denial for all reconsiderations/adjustments/additional payment requests submit a copy of this EOR or clear notation.
- 193, 90563-original payment decision is being maintained. Upon review, it was determined the claim was processed properly.
- P12- Workers' compensation jurisdictional fee schedule adjustment.
- 5283-Additional reimbursement is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies.
- 29-The time limit for filing has expired.
- 4271-Per TX Labor Code Sec 408.027, providers must submit bills to payors within 95 days of the date of service.
- 90590-This bill is a reconsideration of a previously reviewed bill, allowance amounts reflect any changes to the previous payment.

DOS May 26, 2021:

- 00180, 150-Payment adjusted because the payer deems the information submitted does not support this level of service.
- 6270-After review of the bill and the medical record this service is best described by 99213. Submitted documentation did not meet at least 2 of 3 deals.
- 5721-To avoid duplicate bill denial for all reconsiderations/adjustments/additional payment

requests submit a copy of this EOR or clear notation.

- 90460, 219-Based on extent of injury.
- 5029-Payment denied based on extent of injury.
- 18-Exact duplicate claim/service.

Issues

1. Is New Hampshire Insurance Company's denial based on extent of injury is supported?
2. Is New Hampshire Insurance Company's denial based on reason code 29 supported?
3. Is New Hampshire Insurance Company's denial based on documentation does not support level of service billed supported?
4. Is Dr. James Mitchell entitled to reimbursement for CPT code 99213 and 99214?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $616.72 for CPT codes 99080, 99213, and 99214 rendered from February 18 through May 26, 2021.

   According to the explanation of benefits, the carrier denied payment for the disputed services rendered on May 26, 2021 based upon extent of injury.

   28 TAC §133.307(d(2)(H) requires the respondent to submit the following,

   > Response. On receipt of the request, the respondent must provide any missing information not provided by the requestor and known to the respondent. The respondent must also provide the following information and records:) If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier must attach any related Plain Language Notice in accordance with §124.2 of this title (concerning Insurance Carrier Reporting and Notification Requirements).

   A review of the submitted documentation finds the respondent did not submit a Plain Language Notice to support denial was in accordance with rule 124.2. The DWC finds the respondent did not support denial based upon extent of injury.

2. The respondent denied reimbursement for the office visit rendered on April 28, 2021 based upon untimely filing.

   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."

- 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."

The DWC reviewed the submitted documentation and finds:

- The date of service in dispute is April 28, 2021.
- The requestor submitted an EOB dated June 15, 2021that notes bill date May 10, 2021.
- May 10 and June 15, 2021 are within the 95 day deadline for submitting a bill.
- The respondent's denial based upon untimely filing is not supported.

3. The respondent denied reimbursement for CPT code 99213 and 99214 based upon documentation does not support level of service billed.

   The fee guideline for CPT codes 99213 and 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."

   CPT code 99213 is described as, "Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter."

   CPT code 99214 is described as, "Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter."

   A review of the submitted medical reports support billing CPT code 99214 on February 18, 2021, and CPT code 99213 on March 31, April 28, and May 26, 2021. The DWC finds the respondent's denial based upon documentation does not support level of service billed is not supported.

4. 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 Texas Administrative Code §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."

   A. CPT code 99213 and CPT code 99214

   - Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 75211 which is located in Dallas, Texas; therefore, the Medicare locality is "Dallas, Texas."
   - The DWC conversion factor for 2021 is 61.17
   - The Medicare conversion factor for 2021 is 34.8931.

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

   Using the above formula, the MAR is:

| Code | Units | Medicare Payment | MAR or §134.203 (h) Lesser of MAR billed amount | Insurance Carrier Paid | Amount Due |
|---|---|---|---|---|---|
| 99213 | 3 | $93.06 | $163.14 X 3 =$489.42 | $119.21 | $370.21 |
| 99214 | 1 | $132.06 | $231.51 | $0.00 | $231.51 |

B. CPT code 99080-73

CPT code 99080-73 is described as "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form."

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."

The requestor billed for the work status report with CPT code 99080 and modifier 73.

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 did not submit a copy of the May 26, 2021 work status report to support billing per 28 TAC §129.5; therefore, reimbursement is not recommended.

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 additional reimbursement of $601.72 is due.

## Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that New Hampshire Insurance Co. must remit to Dr. James Mitchell $601.72 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

**Authorized Signature**

| | | |
|---|---|---|
| | | 01/18/2022 |
| 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 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.