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

General Information

Requestor Name
Dr. Clarence Wolinski

Respondent Name
New Hampshire Insurance Co.

MFDR Tracking Number
M4-22-0352-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
October 20, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 22, 2021	CPT Code 99203	$257.00	$191.44
	Total	$257.00	$191.44

Requestor's Position

"I have attached the copy of our reconsideration and 99203 is the correct level based on documentation and Total MDM elements score, two of the three elements were meet per our Auditor's review. Please review the attached dispute regarding 99203."

Amount in Dispute: $257.00

Respondent's Position

"It is the carrier's position that in light of the other services, the payment was adjusted because the information submitted did not support the level of service."

Response Submitted by: Flahive, Ogden & Latson

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. 28 TAC §133.20 sets out the rules 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, effective March 1, 2008, sets out the reimbursement guidelines for professional services.

Denial Reasons

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

- 29-The time limit for filing has expired.
- P12-Workers' compensation jurisdictional fee schedule adjustment.
- 309-The charge for this procedure exceeds the fee schedule allowance.
- 168-Payment denied as service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.
- 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.
- 193, 00563-Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.

Issues

1. Is New Hampshire Insurance Company's denial based on timeliness supported?
2. Is New Hampshire Insurance Company's denial based on benefits are not available under the dental plan supported?
3. Is New Hampshire Insurance Company's denial based on the documentation does not support level of service billed supported?

4. Is Dr. Clarence Wolinski entitled to reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $257.00 for CPT code 99203 rendered on March 22, 2021.

   The respondent denied reimbursement based upon reason code "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."

   - 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 March 22, 2021.

- The requestor submitted a Explanation of Benefits dated April 8, 2021 that supports bill was submitted within the 95 day deadline.
- The respondent's denial of payment based upon timely filing is not supported.

2. The respondent also denied payment for CPT code 99203 based upon "168-Payment denied as service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan."

   A review of the submitted medical report supports [redacted]. The respondent did not submit documentation to support the denial regarding the benefits available under a dental plan. The DWC finds the denial based upon reason code 168 is not supported.

3. The respondent also denied payment for CPT code 99203 based upon "150-Payment adjusted because the payer deems the information submitted does not support this level of service," and "5352-Service reduced/denied as level of E&M code submitted is not supported by documentation."

   The fee guidelines for disputed services are found in 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 99203 is described as, "Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30–44 minutes of total time is spent on the date of the encounter."

   The division finds the submitted report supports billing code 99203, therefore, reimbursement is recommended per the fee guideline.

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 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 76302 which is located in Wichita Falls, Texas; therefore, the Medicare locality is "Rest of Texas."
- The Medicare participating amount for CPT code 99203 at this locality is $109.20

Using the above formula, the MAR is $191.44. The respondent paid $0.00. The difference between MAR and amount paid is $191.44.

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 $191.44 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 New Hampshire Insurance Co. must remit to Dr. Clarence Wolinski $191.44 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	11/17/2021 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.