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

General Information

Requestor Name
Clinics of North Texas, LLP

Respondent Name
New Hampshire Insurance Co.

MFDR Tracking Number
M4-22-0718-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
December 14, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 6, 2021	CPT Code 99214	$255.00	$221.76
	Total	$255.00	$221.76

Requestor's Position

"I have attached the copy of our reconsideration and 99214 is the correct level based on documentation and Total MDM elements score, two of the three elements were meet per our Auditor's review."

Amount in Dispute: $255.00

Respondent's Position

"The carrier's position remains the same as it was on it's EOBs."

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, (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:

- 29-The time limit for filing has expired.
- P12-Workers' compensation jurisdictional fee schedule adjustment.
- 193,90563-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 150, 90168-Payment adjusted because the payer deems the information submitted does not support this level of service.
- 00663-Reimbursement has been calculated according to state fee schedule guidelines.
- 309-The charge for this procedure exceeds the fee guideline.
- 5352-Service reduced/denied as Level of E&M code submitted is not supported by documentation.

Issues

1. Is New Hampshire Insurance Company's denial based on reason code 29 supported?
2. Is New Hampshire Insurance Company's denial based on documentation does not support level of service billed supported?

3. Is Clinics of North Texas, LLP entitled to reimbursement for CPT code 99214?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $255.00 for CPT code 99214 rendered on May 6, 2021.

   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."The respondent contends reimbursement is not due because the documentation does not support the level of service billed.
   - 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 date of service in dispute is May 6, 2021.
     - The requestor submitted an EOB dated May 27, 2021that notes bill was received May 12, 2021.
     - May 12, 2021 is within the 95 day deadline for submitting a bill.
     - The respondent's denial based upon untimely filing is not supported.
2. The respondent denied reimbursement for CPT code 99214 based upon documentation does not support level of service billed.

   The fee guideline 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."

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."

The division finds the submitted reports support billing code 99214 ; therefore, reimbursement is recommended per the fee guideline.

3. 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 75231 which is located in Wichita Falls, Texas; therefore, the Medicare locality is "Rest of Texas."
   - The Medicare participating amount for CPT code 99214 at this locality is $126.50.

   Using the above formula, the MAR is $221.76 for CPT code 99214. The respondent paid $0.00. The difference between MAR and amount paid is $221.76.

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 $221.76 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 Clinics of North Texas, LLP $221.76 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	01/18/2022 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.