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

General Information

Requestor Name
Peak Integrated Healthcare

Respondent Name
Old Republic Insurance Co.

MFDR Tracking Number
M4-23-2090-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
April 26, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
11/14 – 12/12/2022	97545-WC	$403.20	$403.20
11/14 – 12/12/2022	97546-WC	$345.60	$345.60
12/09/2022	99361-W1	$113.00	$0.00
01/30/2023	99213	$174.71	$174.71
01/30/2023	99080-73	$15.00	$15.00
	Total	$1,051.51	$938.51

Requestor's Position

*Note that this position statement is taken from the request for reconsideration:
"These dates of service have not been previously paid and were authorized and timely filed…"
Amount in Dispute: $1,051.51

Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed. We will provide a supplemental response once the bill auditing company has finalized their review. Attached is a copy of all bills received to date, as well as the corresponding Explanations of Benefits and payment details."
Response Submitted by: Old Republic Insurance Co., May 15, 2023

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. 28 TAC §134.230 sets out the reimbursement guidelines for return to work rehabilitation programs.
3. 28 TAC §133.20 sets out requirements of timely medical bill submission.
4. 28 TAC §134.203 sets out the fee guideline for professional medical services.
5. 28 TAC §129.5 sets out the fee guidelines for the DWC73 reports.

Denial Reasons

- 247 – A payment or denial has already been recommended for this service.
- B13 – Previously paid. Payment for this claim/ service may have already been provided in a previous payment.
- 193 – original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
- 5283 – Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, provider's contract or car
- 29 – The time limit for filing has expired. [DOS 12/9/2022 and 1/30/2023 only]
- 4271 – Per TX Labor Code Sec 408.027, provider must submit bills to payors within 95 days of the date of service. [DOS 12/9/2022 and 1/30/2023 only]

Issues

1. Did the insurance carrier submit a supplemental position summary as indicated in their DWC060 response?
2. Is the Insurance Carrier's denial of CPT codes 97545-WC and 97546-WC supported?
3. Is the insurance carrier's denial for 95-day timely filing supported for dates of service December 9, 2022 and January 30, 2022?
4. Is the requester entitled to reimbursement for disputed services?

Findings

1. The division notes that it has not received a supplemental position statement response from the insurance carrier or it's respresentative as of the date of this review.

2. The Insurance Carrier (IC) denied reimbursement of CPT codes 97545-WC and 97546-WC rendered on multiple dates of service (DOS) ranging from November 14, 2022 through December 12, 2022. These services were denied based on reason codes 247 and B13, defined above.

   Review of all submitted documentation, to include explanations of benefits (EOB) submitted, finds no evidence that the services in dispute had been previously paid. Therefore, the denial reasons are not supported.

3. The IC denied reimbursement for CPT codes 99361-W1, 99213 and 99080-73 rendered on December 9, 2022 and January 30, 2023 based on denial codes 29 and 4271, defined above as involving compliance with timely filing rules.

   28 TAC §133.20 sets out requirements of timely medical bill submission, states in pertinent part "(b) 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."

   Texas Labor Code §408.0272(b) sets out certain exceptions for untimely submission of a claim, states "(b) 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; or (2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider."

   The division finds no documentation that any of the exceptions to the 95 day timely filing rule, set out in Labor Code §408.0272, exist in this dispute.

Review of submitted documentation finds that the EOB processed on April 19, 2023, for DOS December 9, 2022 and January 30, 2023, confirm that the *medical bill was received by the IC on March 28, 2023*.

The 95 day deadline to submit the medical bill for CPT Code 99361-W1, rendered on December 9, 2022 would have been March 14, 2023, in accordance with 28 TAC §133.20. The division finds that the denial reason, involving 95 day timely filing requirement, is supported for disputed date of service December 9, 2022, in accordance with 28 TAC §133.20.

The 95 day deadline to submit the medical bill for CPT Codes 99213 and 99080-73 rendered on January 30, 2023 would have been May 5, 2023, in accordance with TAC §133.20. The division finds that the denial reason, involving 95 day timely filing requirement, is not supported for disputed date of service January 30, 2023, in accordance with 28 TAC §133.20. Therefore, disputed DOS January 30, 2023, will be adjudicated in accordance with 28 TAC §134.203 and 28 TAC §129.5.

4. Requester is seeking reimbursement in the amount of $403.20 for CPT code 97545-WC and in the amount of $345.60 for CPT code 97546-WC, rendered on the following dates of service: November 14, 15, 16, 17, 28, 30, 2022, and December 12, 2022.

   28 TAC §134.230 applies to the reimbursement of 97545-WC and 97546-WC, states in pertinent part, "(1) 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. (2) For division purposes, General Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Conditioning. (A)The first two hours of each session shall be billed and reimbursed as one unit, using CPT code 97545 with modifier "WC." Each additional hour shall be billed using CPT code 97546 with modifier "WC." CARF accredited programs shall add "CA" as a second modifier. (B)Reimbursement shall be $36 per hour. Units of less than one hour shall be prorated by 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 division finds that a total of 4 hours of work conditioning program are documented on each date November 14, 15, 19, 28, 30, 2022, and a total of 3 hours of work conditioning are documented on each date November 17, 2022 and December 12, 2022. Review of medical bills submitted finds that units were documented and billed in compliance with TAC §134.230.

   In accordance with 28 TAC §134.230, the following calculation is applied to determine MAR for each hour of CPT 97545-WC and 97546-WC rendered:

   - $36.00/hour x 80% (non-CARF provider) of MAR = $28.80/hour MAR for non-CARF accredited provider on disputed dates of service.

- The requester documented and billed a total of 7 units (14 hours) of CPT 97545-WC on disputed dates of service. Using the formula above, 7 units of CPT 97545-WC = $403.20 total MAR for the disputed dates of service.

- The requester documented and billed a total of 12 units (12 hours) of CPT 97546-WC on disputed dates of service. Using the formula above, 12 units of CPT 97546-WC = $345.60 total MAR for the disputed dates of service.

- Submitted documentation finds that the IC reimbursed the requester $0.00 for CPT 97545-WC and 97546-WC on disputed dates of service.

The division finds that in accordance with 28 TAC §134.230, the requester is entitled to $403.20 for CPT code 97545-WC and entitled to $345.60 for CPT code 97546-WC, rendered on the disputed dates of service.

The requester seeks reimbursement for CPT code 99213 rendered on January 30, 2023. The division finds that 28 TAC §134.203 applies to the reimbursement of CPT code 99213.

28 TAC §134.203 states in pertinent part, "(c) 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... (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..."

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

- The 2023 DWC Conversion Factor is 64.83.
- The 2023 Medicare Conversion Factor is 33.8872.
- Per the medical bill, the services were rendered in zip code 75043; the Medicare locality is 11, Dallas.
- The Medicare Participating amount for CPT code 99213 at this locality in 2023 is $91.33.
- Using the formula above, MAR for CPT code 99213 in locality 11, on January 30, 2023 is $174.72.
- The IC reimbursed the requester $0.00 for disputed service 99213.
- Reimbursement in the amount of $174.71 (amount charged on medical bill) is recommended for CPT code 99213 rendered on disputed DOS, January 30, 2023.

The division finds that the requester is entitled to reimbursement in the amount of $174.71 for CPT code 99213 rendered on January 30, 2023.

The requester is seeking reimbursement in the amount of $15.00 for CPT code 99080-73, work status report, rendered on January 30, 2023.

The division finds that 28 TAC §129.5 applies to the reimbursement of 99080-73. 28 TAC §129.5 sets out the fee guidelines for the DWC73 reports 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."

A review of the submitted documentation finds that the DWC-73 Work Status Report rendered on January 30, 2023, is in compliance with requirements set out by 28 TAC §129.5. Therefore, the division finds that the requester is entitled to reimbursement of $15.00 for service code 99080-73 rendered on January 30, 2023.

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.

The division finds the requester has established that reimbursement in the amount of $938.51 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 the Respondent, Old Republic Insurance Co., must remit to the Requestor, Peak Integrated Healthcare, $938.51 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 22, 2023
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.