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**
Marvin Van Hal, M.D.

**Respondent Name**
Zurich Insurance Co.

**MFDR Tracking Number**
M4-23-2294-01

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

**DWC Date Received**
May 16, 2023

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| 10/24/2022 | 99213 | $150.00 | $150.00 |
| 10/24/2022 | 99080 | $65.00 | $15.00 |
| | **Total** | $215.00 | $165.00 |

## Requestor's Position

"…this claim was billed in a timely manner; but it was sent to the employer. We were told to send the claims to the employer as bill the employer. I called and find out that they should have been sent to Gallagher Bassett; I am resubmitting the claim… This is not a duplicate!…"

**Amount in Dispute:** $215.00

## Respondent's Position

"…The provider noted that the medical bill was initially sent to the employer. The process is allowed under Rule 133.20G) but as such, the provider is not entitled to medical dispute resolution. If it was a mistake to have sent the bill to the employer, then the question arises as to whether the provider timely submitted the medical bill to the carrier. Section 408.0272 of the Texas Labor Code provides for certain exceptions to the 95-day submission rule. However, those exceptions do not include the submission of the bill initially to the employer…"

**Response Submitted by:** Zurich Insurance Co.

## 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 Medical Fee Dispute Resolution requests.
2. 28 TAC §133.20 sets out requirements of medical bill submission by health care providers.
3. 28 TAC §134.203 sets out the fee guideline for professional medical services.
4. 28 TAC §129.5 sets out the fee guidelines for the DWC73 reports.

Denial Reasons

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

- 29 – The time limit for filing has expired.
- 4271 – Per TX Labor Code Sec. 408.027, providers must submit bills to payers within 95 days of the date of service.
- 247 - A payment or denial has already been recommended for this service.

Issues

1. Has Marvin Van Hal, M.D., waived their right to medical fee dispute resolution (MFDR)?
2. Is the requester entitled to reimbursement for services rendered on October 24, 2022.

Findings

1. The insurance carrier denied (IC) reimbursement on disputed services with reason code 29, defined above. 28 Texas Administrative Code §133.20(b) 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… 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 being October 24, 2022, the deadline for requester to submit the medical bill to the IC would have been January 27, 2023, which is 95 days from disputed date of service. Review of submitted documentation finds an explanation of benefits (EOB) from Gallagher Bassett showing a medical bill date of January 18, 2023, less than 95 days after date of services rendered. Submitted documentation also includes a copy of injured employee billing ledger showing that the IC, Gallagher Bassett, was billed on January 18, 2023.

The division finds that the requester, Marvin Van Hal, M.D., has not waived their right to MFDR. Therefore, the disputed services will be adjudicated in accordance with 28 TAC §133.203 and 28 TAC §129.5, described above under statutes and rules section.

2. The requester is seeking reimbursement in the amount of $150.00 for CPT code 99213 and in the amount of $65.00 for service code 99080-73, work status report, both services rendered on October 24, 2022.

CPT Code 99213 involves the evaluation and management (E/M) of an established patient, outpatient office visit. The division finds that 28 TAC §133.203 applies to the reimbursement of CPT code 99213 states in pertinent part, "(c) To determine the maximum allowable reimbursement (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…"

28 TAC §134.203 Medical Fee Guideline for Professional Services, states in pertinent part:
(a) (5) "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.
(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

(1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules…

(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, *reimbursement shall be the least of the*:

(1) MAR amount;

(2) *health care provider's usual and customary charge*, unless directed by Division rule to bill a specific amount; or

(3) fair and reasonable amount consistent with the standards of §134.1 of this title.

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

Disputed date of service CPT code 99213 was rendered in 2022.

- The 2022 DWC Conversion Factor is 62.46
- The 2022 Medicare Conversion Factor is 34.6062
- Per the medical bills, the service was rendered in zip code 76053; the Medicare locality is 28.
- The Medicare Participating amount for CPT code 99213 at this locality in 2022 is $90.96.
- Using the above formula, the division finds the MAR is $164.17.
- The requester charged $150.00.
- The respondent paid $0.00.
- The requestor is due $150.00, *the least of* the MAR and provider's usual customary charge, for date of service October 24, 2022.

On the disputed date of service, the requester rendered and billed for service code 99080-73, a Work Status report. 28 TAC §129.5(i)(1) applies to the reimbursement of Work Status 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."

Review of the DWC-73 report rendered on October 24, 2022, finds that the requestor met the documentation requirements outlined in 28 TAC §129.5, therefore, reimbursement of $15.00 is recommended for this report.

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 is due.

## Order

Under Texas Labor Code §§413.031 and 413.019, the Division has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent, Zurich Insurance Co., must remit to the Requestor, Marvin Van Hal, M.D., $165.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

**Authorized Signature:**

| | | June 12, 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.tas.gov.