MEDICAL CONTESTED CASE HEARING NO. 09101
M4-09-1662-01

DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and Rules of the Division of Workers' Compensation adopted thereunder.

ISSUES

A contested case hearing was held on February 20, 2009, to decide the following issue:

1. Whether the preponderance of the evidence is contrary to the decision of Medical Review that Respondent/Subclaimant is entitled to additional reimbursement in the amount of $650.00 plus applicable accrued interest for date of service of December 31, 2007?

PARTIES PRESENT

Claimant did not appear and his appearance was waived by the parties. Petitioner/Carrier appeared by and was represented by BJ, attorney. Respondent/Subclaimant appeared and was represented by Dr. B, M.D.

BACKGROUND INFORMATION

RB, TB, and TH, all testified at the February 20, 2009, medical fee dispute CCH. Dr. B, M.D., was Claimant's treating doctor, and on December 31, 2007, performed a very thorough impairment rating evaluation. There is no dispute that the service was provided, the billing procedures are at the heart of this dispute.

Rule 134.202(a) (1) and (2) provide that this section applies to professional medical services (health care other than prescription drugs or medicine, and the facility services of a hospital or other health care facility) provided in the Texas Workers' Compensation system, and that this section shall be applicable for professional medical services provided on or after September 1, 2002.

Rule 134.202(b) provides that for coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section.

Rule 134.202(e) provides that payment policies relating to coding, billing, and reporting for commission-specific codes, service, and programs are as follows:

> (1) Billing: Health care providers (HCPs) shall bill their usual and customary charges. HCPs shall submit medical bills in accordance with subsection (b), the Act, and commission rules.

(2) Modifiers. Modifying circumstances shall be identified by use of the appropriate modifier following the appropriate American Medical Association (AMA) Physician's Current Procedural Terminology (CPT) code. Additionally, commission specific modifiers are identified in paragraph (9) of this section. When two modifiers are applicable to a single CPT code, indicate each modifier on the bill.

Rule 134.202 (e)(6)(C)(i) provides: The following applies for billing and reimbursement of an MMI evaluation.

(i) An examining doctor who is the treating doctor shall bill using the "Work related or medical disability examination by the treating physician..." CPT code with the appropriate modifier.

Rule 134.202 (e)(9) (O) provides: V5, Level of MMI for Treating Doctor - this modifier shall be added to the "Work related or medical disability examination by the treating physician..." CPT code when the office visit level of service is equal to "moderate to high severity" level and of at least 45 minutes duration.

On January 2, 2008, health care provider submitted a bill for $650.00 for date of service of December 31, 2007. The CPT code billed was **99456** and the modifier was **WP.** On February 12, 2008, the insurance carrier audited the bill and provided an explanation of benefits (EOB), denying the bill because:

CAC-4 The procedure code is inconsistent with the modifier used or a required modifier is missing; and

732 Accurate coding is essential for reimbursement. Services are not reimbursable as billed. CPT and/or modifier billed incorrectly.

Admitted into evidence as Hearing Officer Exhibit #4, is a copy of *current procedural terminology cpt 2007, AMA American Medical Association 2007, at 33,* that provides the following information related to CPT codes:

99455 Work related or medical disability examination by the **treating physician** that includes:

- **Completion of a medical history commensurate with the patient's condition;**
- **Performance of an examination commensurate with the patient's condition;**
- **Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment;**
- **Development of future medical treatment plan; and**
- **Completion of necessary documentation/certificates and report.**

99456 Work related or medical disability examination by **other than the treating physician** that includes:

- **Completion of a medical history commensurate with the**

patient's condition;

- **Performance of an examination commensurate with the patient's condition;**
- **Formulation of a diagnosis, assessment of capabilities and stability and calculation of impairment;**
- **Development of future medical treatment plan; and**
- **Completion of necessary documentation/certificates and report.**

On April 13, 2008, health care provider submitted a "corrected claim" bill to the insurance carrier for $650.00 for date of service of December 31, 2007. The CPT code billed was still **99456** and the modifiers were **WP and V5.**

On May 1, 2008, the insurance carrier audited the bill and provided an explanation of benefits (EOB) denying the bill because:

CAC-W4	No additional reimbursement allowed after review of appeal/reconsideration;
CAC-4	The procedure code is inconsistent with the modifier used or a required modifier is missing;
732	Accurate coding is essential for reimbursement. Services are not reimbursable as billed. CPT and/or modifier billed incorrectly; and
891	The insurance company is reducing or denying payment after reconsideration.

On May 9, 2008, Respondent/Subclaimant submitted a bill for $650.00 for date of service of December 31, 2007. The CPT code billed was changed to **99455** and the modifiers were "**WP and V5."**

On June 16, 2008, Petitioner/Carrier audited the bill and provided an explanation of benefits (EOB) denying the bill because:

CAC-29	The time limit for filing has expired; and
731	134.801 and 133.20 provider shall not submit a medical bill later than the 95th day after the date of service, for service on or after 9/1/05.

Medical fee dispute resolution was requested by the Respondent/Subclaimant, and on December 3, 2008, Medical Fee Dispute issued a determination that based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, "The Division has determined that the Requestor is entitled to reimbursement. The Division hereby orders the Carrier to remit to the Requestor the amount of $650.00 plus applicable accrued interest per Division Rule 134.100 within 30 days of receipt of this order. "

The rationale for the decision was:

> The medical bills were timely submitted per TAC 133.250(d)(1). Specifically, the Requestor submitted an EOB from the carrier dated 02/12/08. This date is within the 95-day period after the services were provided on 12/31/2007. Per TAC 133.250 (d)(1) A

> Reconsideration request may include corrections relating to modifiers and/or number of units. For this reason a request for reconsideration may include changes in the number of units or modifiers from that in the original bill for proper processing and payment of bill.

Petitioner/Carrier requested a medical fee CCH.

As seen by evidence presented at the February 20, 2009, CCH, the January 2, 2008, bill that was originally submitted was billed using the wrong CPT code and missing a modifier. The bill was then resubmitted on April 13, 2008, still with the wrong CPT code, although the missing modifier had now been added. Then on May 9, 2008, the bill was resubmitted with the correct CPT code and the correct modifiers. However, pursuant to Rule 133.20 (b) a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. The date of service was December 31, 2007, and the 95th day after the date the services were provided was April 4, 2008.

With respect to the Medical Review decision findings and determination, while the preamble to Rule 133.250(d)(1) states that a reconsideration may include corrections relating to modifiers and/or number of units, Rule 133.250(d)(1) actually provides is as follows:

> (d) The request for reconsideration shall:
>
> (1) reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill.

In the instant case "reconsideration" is not the issue because "reconsideration" involves a reconsideration of the same billing codes, date(s) of service, and dollar amounts as the original bill. Because the Respondent/Subclaimant had not correctly billed for its services, it needed to change the CPT code, which would constitute a new bill, not a request for reconsideration. The Respondent/Subclaimant had until April 4, 2008, to submit a new bill that correctly identified the CPT code, which it failed to do.

When the Respondent/Subclaimant finally properly billed using the correct CPT code on May 9, 2008, the 95-day deadline had expired. Thus, Respondent/Subclaimant is not entitled to additional reimbursement in the amount of $650.00 plus applicable accrued interest for date of service of December 31, 2007.

Even though all the evidence presented was not discussed, it was considered. The Findings of Face and Conclusions of Law are based on all of the evidence presented.

FINDINGS OF FACT

1. The parties stipulated to the following facts:

   A. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.

   B. On _____, Claimant was the employee of (Employer), and sustained a compensable injury.

2. Petitioner/Carrier delivered to Respondent/Subclaimant a single document stating the true corporate name of Petitioner/Carrier, and the name and address of Petitioner/Carrier's registered agent, which document was admitted into evidence as Hearing Officer's Exhibit Number 2.

3. On December 31, 2007, Respondent/Subclaimant was Claimant's treating doctor, and performed an impairment rating on Claimant.

4. On January 2, 2008, Respondent/Subclaimant submitted a bill for $650.00 for date of service of December 31, 2007, to Petitioner/Carrier using the incorrect CPT code of 99456 and omitting a necessary modifier of V5.

5. On February 12, 2008, Petitioner/Carrier audited and denied the bill, and sent Respondent/Subclaimant an explanation of benefits (EOB).

6. On April 13, 2008, Respondent/Subclaimant submitted a "corrected claim" to the Petitioner/Carrier still using the incorrect CPT code of 99456, but with necessary modifiers of WP and V5.

7. The 95th day after the initial date of service was April 4, 2008.

8. When the Respondent/Subclaimant correctly changed the CPT code and submitted it to the Petitioner/Carrier on May 9, 2008, this constituted a new bill for date of service of December 31, 2007, and pursuant to Section 408.027(a) of the Labor Code, the Respondent/Subclaimant did not submit a claim for payment to the Petitioner/Carrier not later than the 95th day after the date on which the health care services were provided.

CONCLUSIONS OF LAW

. 1. The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction to hear this case.

2. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.

3. The preponderance of the evidence is contrary to the decision of Medical Review that Respondent/Subclaimant is entitled to additional reimbursement in the amount of $650.00 plus applicable accrued interest for date of service of December 31, 2007.

DECISION

The preponderance of the evidence is contrary to the decision of Medical Review that Respondent/Subclaimant is entitled to additional reimbursement in the amount of $650.00 plus applicable accrued interest for date of service of December 31, 2007.

ORDER

Petitioner/Carrier is not liable for the benefits that were at issue in this hearing. Claimant remains entitled to medical benefits for the compensable injury in accordance with §408.021.

The true corporate name of the insurance carrier is **TEXAS MUTUAL INSURANCE COMPANY,** and the name and address of its registered agent for service of process is:

RUSSELL OLIVER, PRESIDENT
TEXAS MUTUAL INSURANCE COMPANY
6210 EAST HIGHWAY 290
AUSTIN, TEXAS 78723

Signed this 23rd day of February, 2009.

Cheryl Dean
Hearing Officer