Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
COLLOM & CARNEY CLINIC

Respondent Name
AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number
M4-12-0870-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
NOVEMBER 14, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The following is a breakdown of my attempts to collect payment on the attached 5 bills-

- The first submission was sent electronically through StoneRiver P2P Link in February and March 2011 (proof attached)
- The second submission was sent electronically through StoneRiver P2P Link again in May 2011 except 2.10.11 $173.25 (proof attached)
- The third submission was sent via mail after I contacted Zurich bill review and was told they had not received any of these bills

With the third sub I typed a cover letter with proof from P2P's web site along with all bills and documentation showing they were submitted within 95 days from dates of service. I called bill review on 9/2/11 and spoke with Brian. He stated bills had been received and he would forward to the adjuster for payment. I received one denial back for dos 2/10/11 $47.25 stating time limit had expired. I called Zurich bill review on 10/5/11 and spoke with Bianca. She sated they still showed no proof of receiving the other four bills although all five bills were mailed in the same envelope."

Amount in Dispute: $1,882.75

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 10, 2011	CPT Code 93010 Electrocardiogram with Interpretation and Report	$47.25	$13.90
February 10, 2011	CPT Code 93005 Electrocardiogram without Interpretation and Report	$57.25	$16.45
February 10, 2011	CPT Code 36415 Collection of Venous Blood by Venipuncture	$20.25	$0.00
February 10, 2011	CPT Code 85025 Laboratory Testing on Blood	$48.00	$0.00

February 10, 2011	CPT Code 80053 Laboratory Testing Metabolic Panel	$105.00	$0.00
February 11, 2011	CPT Code 64721-LT Carpal Tunnel Surgery	$1,590.00	$814.55
February 28, 2011	CPT Code 99080-73 Work Status Report	$15.00	$15.00
TOTAL		$1,882.75	$859.90

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
2. 28 Texas Administrative Code §133.307, effective June 1, 2012 sets out the procedures for resolving a medical fee dispute.
3. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
4. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
5. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets out medical fee guidelines for workers' compensation specific services.
6. 28 Texas Administrative Code §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
7. The services in dispute were reduced / denied by the respondent with the following reason codes:
   Date of service February 10, 2011 – CPT Code 93010
   - 200-Per 134.801, a medical bill shall not be submitted later than the 1st day of the 11th month (<08/31/05) or (95 days (>09/01/05) after DOS.
   - 29-The time limit for filing has expired.

   Neither party to the dispute submitted explanation of benefits for the remaining disputed services rendered on February 10, 2011 through February 28, 2011.

8. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on November 18, 2011. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Issues

1. Did the requestor support position that the disputed bills were submitted timely?
2. Is the requestor entitled to reimbursement for codes 93010, 93005, and 64721?
3. Is the requestor entitled to reimbursement for codes 36415, 85025, and 80053?
4. Is the requestor entitled to reimbursement for code 99080-73?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for code 93010 based upon reason codes "29," and "200." The requestor indicates in the position summary that "With the third sub I

typed a cover letter with proof from P2P's web site along with all bills and documentation showing they were submitted within 95 days from dates of service."

Texas Labor Code §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 Texas Administrative Code §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."

The requestor submitted copies of P2P Link Reports that indicate the following:

Date of Service	Total Charged	Date Mailed	Status
February 10, 2011	$173.25	February 17, 2011	(PNM) Printed and Mailed
February 10, 2011	$57.25	February 17, 2011 May 9, 2011	(PNM) Printed and Mailed
February 10, 2011	$47.25	February 23, 2011 May 9, 2011	(PNM) Printed and Mailed
February 11, 2011	$1,590.00	March 14, 2011 May 9, 2011	(PNM) Printed and Mailed
February 28, 2011	$15.00	March 9, 2011 May 9, 2011	(PNM) Printed and Mailed

The Division finds that the requestor has supported position that bills were submitted in accordance with Texas Labor Code §408.027(a). As a result, reimbursement in accordance with Division rules and fee guideline is recommended.

2. 28 Texas Administrative Code §134.203(b)(1) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: 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."

   Per 28 Texas Administrative Code §134.203(c)(1)(2), "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. 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. 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 Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2011 DWC conversion factor for this service is 54.54/68.47.

The Medicare Conversion Factor is 33.9764

Review of Box 32 on the CMS-1500 the services were rendered in Texarkana, Texas. Per Medicare the provider is reimbursed using the locality of "Rest of Texas".

Using the above formula, the Division finds the following:

Code	Medicare Participating Amount	MAR	Total Paid	Total Due
93010	$8.66	$13.90	$0.00	$13.90
93005	$10.25	$16.45	$0.00	$16.45
64721	$404.20	$814.55	$0.00	$814.55

3. On February 10, 2011, the requestor billed CPT codes 36415, 85025 and 80053.
   - CPT code 36415 is defined as "Collection of venous blood by venipuncture."
   - CPT code 85025 is defined as "Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count."
   - CPT code 80053 is defined as "Comprehensive metabolic panel This panel must include the following: Albumin (82040) Bilirubin, total (82247) Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphatase, alkaline (84075) Potassium (84132) Protein, total (84155) Sodium (84295) Transferase, alanine amino (ALT) (SGPT) (84460) Transferase, aspartate amino (AST) (SGOT) (84450) Urea nitrogen (BUN) (84520)."

   On February 11, 2011, the requestor billed CPT code 64721 which is defined as "Neuroplasty and/or transposition; median nerve at carpal tunnel." Per Medicare guideline CPT code 64721 is classified as a major surgery with a global period of 90 days. Per Medicare Learning Network Matters Number SE1323, the global surgery package "GSP was established by CMS to ensure that all components of surgery (including pre- and post-operative services were bundled into one payment." Because the codes 36415, 85025 and 80053 were performed in the pre-operative period, they are bundled into the payment for code 64721. As a result, reimbursement is not recommended.

4. CPT code 99080-73 is defined as "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form."

   28 Texas Administrative Code §134.204(l) states "The following shall apply to Work Status Reports. When billing for a Work Status Report that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section, refer to §129.5 of this title (relating to Work Status Reports)."

   28 Texas Administrative Code §129.5(i)(1) 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 Texas Administrative Code §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.

   The requestor submitted a copy of the work status report to support claimant was released to return to work as of February 28, 2011; therefore, reimbursement of $15.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $859.90.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $859.90 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		02/20/15
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 in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.