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
ORTHOTEXAS PHYSICIANS AND SURGEONS

Respondent Name
TRAVELERS INDEMNITY CO

MFDR Tracking Number
M4-12-1574-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
JANUARY 12, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On these dates of service, the treatment was denied as untimely filing. We submit our claims electronically and I have attached a copy from our clearinghouse, Realmed, providing that you received this claim. Per the Division of Workers Comp, we can use these reports as our proof of timely filing."

Amount in Dispute: $1,504.21

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider performed the services and submitted billing to their electronic billing partner, Realmed. The billing was ultimately received by the Carrier and denied based on the failure to timely submit the billing. The Provider requested reconsideration and the Carrier upheld the denial of reimbursement…The Provider alleges they timely submitted the billing through their e-bill vendor, Realmed. In support of that contention, the Provider submits documentation from Realmed purporting that the billing was 'Confirmed by the payor or client…The Carrier has no record of providing a confirmation to Realmed in the timeframes alleged by Realmed, and cannot comment on Realmed's assertion that they received confirmation, from whom the confirmation was received, or what that confirmation contained. The Carrier would point out that Realmed's confirmation does not state from whom confirmation was received. Consequently, it appears that Realmed is receiving the billing electronically from the Provider, dropping it to paper, and submitting the paper billing to the Carrier. Confirmation was not received from the Carrier as the original bill had not been received at that time.'"

Response Submitted by: William E. Weldon/Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 1, 2011	CPT Code 99205 Office Visit	$194.44	$194.44
April 1, 2011	CPT Code 72040 Cervical Spine X-ray	$51.98	$51.98
April 1, 2011	CPT Code 72100 Lumbar Spine X-ray	$54.53	$54.53
April 6, 2011	CPT Code 99214 Office Visit	$143.74	$143.74
April 6, 2011	CPT Code 73110-LT Wrist X-ray	$48.18	$48.18

April 6, 2011	CPT Code 73565-RT Both Knees X-ray	$56.07	$52.46
April 6, 2011	HCPCS Code L3807-LT Wrist Orthosis	$95.00	$95.00
April 6, 2011	HCPCS Code L0626 Lumbar Orthosis	$95.00	$88.61
April 12, 2011	CPT Code 72148 Lumbar MRI	$654.35	$654.35
April 28, 2011	CPT Code 99213 Office Visit	$95.92	$95.92
April 28, 2011	CPT Code 99080-73 Work Status Report	$15.00	$15.00
TOTAL		$1,504.21	$1,494.21

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 May 25, 2008 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 §134.204, effective March 1, 2008, sets out medical fee guidelines for workers' compensation specific services.
5. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
6. The services in dispute were reduced / denied by the respondent with the following reason codes:
   - TXH3, 29-The time limit for filing has expired. Per Texas Labor Code 480.027, bills must be sent to the carrier on a timely basis, within 95 days from dates of service.
   - W4-No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Were the services billed to a workers' compensation carrier timely?
2. Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the disputed service based upon reason codes "TXH3", and "29."

   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 Realmed Claim History reports that support an electronic claim was sent for the disputed dates of service within the timeframe outlined in Texas Labor Code §408.027(a). In addition, the Division reviewed an explanation of benefits report dated August 12, 2011, for dates of service April 1, 6, and 27, 2011 that shows that payment was denied for dates of service April 1 and 6, 2011 but, April 27, 2011 was paid. The Document Number on the Realmed report corresponds to the Patient Control number on the EOBs. The Division concludes that the greater weight of evidence supports requestor's position.

2. 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.

   The Medicare Conversion Factor is 33.9764

   Review of Box 32 on the CMS-1500 the services were rendered in Frisco, 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	Maximum Allowable Reimbursement	Total Amount Paid	Total Amount Due
99205	$191.91	$308.06, the requestor is seeking $194.44	$0.00	$194.44
72040	$37.58	$60.32, the requestor is seeking $51.98	$0.00	$51.98
72100	$39.18	$62.89, the requestor is seeking $54.53	$0.00	$54.53
99214	$99.32	$159.43, the requestor is seeking $143.74	$0.00	$143.74
73110	$34.93	$56.07, the requestor is seeking $48.18	$0.00	$48.18
73565	$32.68	$52.46	$0.00	$52.46
72148	$444.99	$714.31, the requestor is seeking $654.35	$0.00	$654.35

99213	$66.90	$107.39, the requestor is seeking $95.92	$0.00	$95.92

In addition to the professional services listed in the Table above, the requestor is also seeking reimbursement for a wrist and lumbar orthosis, HCPCS codes L3807-LT and L0626.

28 Texas Administrative Code §134.203(d)(1) states "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule."

- According to the DMEPOS fee schedule, HCPCS code L3807 has a total allowable of $206.94; therefore, $206.94 X 125% = $258.67, the requestor is seeking $95.00; this amount is recommended for reimbursement.
- According to the DMEPOS fee schedule, HCPCS code L0626 has a total allowable of $70.89; therefore, $70.89 X 125% = $88.61; this amount is recommended for reimbursement

The requestor is also seeking reimbursement for CPT code 99080-73.

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."

The requestor submitted copies of the work status reports filed on April 28, 2011. As a result, the requestor is due $15.00 for reimbursement

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 $1,494.21.

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 $1,494.21 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	08/15/2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

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