



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Elite Healthcare North Dallas

Respondent Name

New Hampshire Insurance Company

MFDR Tracking Number

M4-15-1922-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

February 26, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached dates of services 3/10/14 and 3/31/14 were not paid in full.

Date of service 3/10/14:

- EOB dated 4/23/14 states 'claim/service lacks information or has submission billing errors which is needed for adjudication.'
-EOB dated 6/4/14 states 'duplicate'.
-EOB dated 7/16/14 states 'claim/service lacks information or has billing errors which is needed for adjudication', yet the Cpt code 99080 DWC-73 was PAID!
-EOB dated 11/10/14 states 'payer deems the information submitted does not support this level of service.'
-EOB dated 12/31/14 states 'the time limit for filing is expired.'

Date of service 3/31/14:

- EOB dated 4/24/14 states 'claim/service lacks information or has submission billing errors which is needed for adjudication.'
-EOB dated 6/4/14 states 'duplicate.'
-EOB dated 7/15/14 states 'service not furnished directly to the patient and/or not documented', yet the Cpt code 99080 DWC-73 was PAID!
-EOB dated 11/5/14 states 'the procedure code is inconsistent with the provider type/specialty (taxonomy)', yet the physical therapy was PAID!"

Amount in Dispute: \$243.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Response dated March 20, 2015: "After review of all received documentation, additional allowance has been recommended for DOS 3/31/2014. An adjustment is in progress and will be issued once finalized.

For DOS 3/10/2014, Coventry stands behind our review.

99213 is denied 'Date(s) of service exceed time period for submission per Rule 133.250(b).

On prior appeals (1-3) 99214 was denied 'THE LEVEL OF E & M CODE SUBMITTED IS NOT SUPPORTED BY DOCUMENTATION'.

<http://www.tdi.texas.gov/wc/rules/documents/wcrules.pdf>

133.250. Reconsideration for Payment of Medical Bills.

(b) The health care provider shall submit the request for reconsideration no later than 10 months from the date of service.

Date of service is 03/10/14 reconsiderations due by 01/10/15

Provider did submit prior iterations within the time frame billing 99214 and continued to be denied by Clinical Validation. Provider submitted corrected bill under the 4th appeal, changed from 99214 to 99213. Bill was received after 10 month time period, 02/25/15. Denial is appropriate.”

Supplemental response dated April 8, 2015: “Clinical Validation (CV) recommended additional allowance, but per fee schedule guidelines, the information needed for CV to allow 99213 was not received within the 10 month time period:

Date(s) of service exceed time period for submission per Rule 133.250(b).

<http://www.tdi.texas.gov/wc/rules/documents/wcrules.pdf>

133.250. Reconsideration for Payment of Medical Bills.

(b) The health care provider shall submit the request for reconsideration no later than 10 months from the date of service.

00 iteration received 04/14/14 bill was denied F262 – The provider’s State Billing License Number is Invalid or was not received pursuant to Texas Rule 133.10.

Per review of the bill billing license number was not provided. Denial was appropriate.

02 iteration received 06/27/14 bill was denied XV41-CVC – Documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge. Please submit documentation to substantiate charges.

04 iteration was received 10/09/14 99213 was denied V130 – CV: PROCEDURE IS OUTSIDE OF THE NORMAL SCOPE OF PRACTICE FOR THIS PROVIDER TYPE.

06 iteration was received 02/25/15 was denied V130-CV: PROCEDURE IS OUTSIDE OF THE NORMAL SCOPE OF PRACTICE FOR THIS PROVIDER TYPE.

08 iteration now allowing 99213 however is setting F287

Date of service is 03/31/14 reconsiderations due by 01/25/15.

It appears information needed for CV to allow 99213 was not received within 10 month time period. Denial is appropriate.

Coventry stands behind our review.”

Response Submitted by: Gallagher Bassett Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 10 and 31, 2014	Evaluation & Management (99213) & Work Status Form (99080-73)	\$243.90	\$15.00

FINDINGS AND DECISION

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

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §133.210 defines the requirements for medical documentation.
3. 28 Texas Administrative Code §133.250 sets out the procedures for reconsideration for payment of medical bills.
4. 28 Texas Administrative Code §129.5 sets out the procedures for Work Status Reports.
5. 28 Texas Administrative Code §134.203 sets out the fee guidelines for billing and reimbursing professional medical services.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - For date of service 3/10/14, CPT Code 99213:
 - 29 – The time limit for filing has expired.
 - For date of service 3/31/14, CPT Codes 99213 and 99080-73:
 - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
 - 18 – Duplicate claim/service.

Issues

1. What is the timely filing deadline for date of service March 10, 2014 in this dispute?
2. Did the requestor forfeit the right to reimbursement for date of service March 10, 2014 in this dispute?
3. Was the insurance carrier's denial of date of service March 31, 2014 supported?
4. Did the requestor support the disputed charges for date of service March 31, 2014?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied the disputed services with claim adjustment reason codes: 29 – “THE TIME LIMIT FOR FILING HAS EXPIRED.” 28 Texas Administrative Code §133.20(b) requires that, except as provided in Texas Labor Code §408.0272, “a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.” Texas Labor Code §408.0272(b) provides that:

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.

To be considered a request for reconsideration, the billing must adhere to the requirements found in 28 Texas Administrative Code §133.250, which states, in relevant part, “(d) A written 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” [emphasis added].

No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to CPT Code 99213 billed for date of service March 10, 2014. For that reason, the health care provider was required to submit the medical bill not later than 95 days after the date the disputed services were provided.

2. Texas Labor Code §408.027(a) states that “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 that:

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.

Review of the submitted information finds no documentation to support that a medical bill was submitted within 95 days from the date the services were provided. Consequently, the requestor has forfeited the right to reimbursement due to untimely submission of the medical bill, pursuant to Texas Labor Code §408.027(a).

3. For date of service March 31, 2014, the insurance carrier denied CPT Code 99213 and 99080-73 with claim adjustment code 16 – “CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION.”

28 Texas Administrative Code §133.210 (b) states, “When submitting a medical bill for reimbursement, the health care provider shall provide required documentation in legible form, unless the required documentation was previously provided to the insurance carrier or its agents.” 28 Texas Administrative Code §129.5 (d) requires that “the doctor shall file the Work Status Report: (2) when the employee experiences a change in work status or a substantial change in activity restrictions.” Review of the submitted documentation finds that the requestor documented a change in activity restrictions for the injured employee. Thus, a Work Status Report was required. Submitted documentation supports that this report was submitted with a request for reconsideration on August 7, 2014. Therefore, the insurance carrier’s denial of 99080-73 was not supported.

Further, 28 Texas Administrative Code §133.210 (c) states, in relevant part, “In addition to the documentation requirements of subsection (b) of this section, medical bills for the following services shall include the following supporting documentation: (1) the **two highest** Evaluation and Management office visit codes for new and established patients: office visit notes/report satisfying the American Medical Association requirements for use of those CPT codes” [emphasis added]. The disputed charges for date of service March 31, 2014 includes Evaluation and Management office visit code 99213, which does not require documentation pursuant to 28 Texas Administrative Code §133.210.

Further, the process for a carrier’s request of documentation not otherwise required by 28 Texas Administrative Code §133.210 is described in section (d) of that section as follows:

“Any request by the insurance carrier for additional documentation to process a medical bill shall:

- (1) be in writing;
- (2) be specific to the bill or the bill's related episode of care;
- (3) describe with specificity the clinical and other information to be included in the response;
- (4) be relevant and necessary for the resolution of the bill;
- (5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;
- (6) indicate the specific reason for which the insurance carrier is requesting the information; and
- (7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation.”

No documentation was found to support that the carrier made an appropriate request for additional documentation with the specificity required by §133.210(d). The Division concludes that carrier failed to meet the requirements of 28 Texas Administrative Code 133.210(d). The carrier’s denial of 99213 is not supported.

4. For the reasons stated above, the Division finds that the requestor supported the disputed charge for CPT Code 99080-73.

28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, “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; ... and other payment policies in effect on the date a service is provided...” Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and

management of an established patient.

The American Medical Association (AMA) CPT code description for 99213 is:

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: **An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity** [emphasis added]. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.

The 1997 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare guideline to determine the documentation requirements for the service in dispute. Review of the documentation finds the following:

- Documentation of the Expanded Problem Focused History:
 - “A *brief* [History of Present Illness (HPI)] consists of one to three elements of the HPI [or may include the status of 1-2 chronic or inactive conditions].” Documentation found that the requestor reviewed two elements of HPI, thus meeting the requirement for this element.
 - “A *problem pertinent* [Review of Systems (ROS)] inquires about the system directly related to the problem(s) identified in the HPI.” Documentation found one system was reviewed (musculoskeletal, which was pertinent to the condition documented in HPI). This element was met.
 - A Past Family, and/or Social History (PFSH) is not required for this component.

The Guidelines state, “To qualify for a given type of history all three elements in the table must be met.” A review of the submitted documentation indicates that all elements were met for this component of CPT Code 99213.

- Documentation of the Expanded Problem Focused Examination:
 - An “*expanded problem focused* [examination should include] a limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s).” A review of the submitted documentation does not support that an examination was performed. Therefore, this component of CPT Code 99213 was not met.
- Documentation of Decision Making of Low Complexity:
 - *Number of diagnoses or treatment options* – Review of the submitted documentation finds that there were no new diagnoses presented, but that an established diagnosis was stable or improved, meeting the documentation requirements of minimal complexity.
 - *Amount and/or complexity of data to be reviewed* – Review of the documentation finds that the requestor ordered no new tests and reviewed no records from other sources. This meets the requirements for minimal complexity.
 - *Risk of complications and/or morbidity or mortality* – Review of the submitted documentation finds that presenting problems include one stable, chronic injury, which presents a low level of risk. Work hardening was recommended, which presents a low level of risk. “The highest level of risk in any one category...determines the overall risk.” The documentation supports that this element met the criteria for low risk.

“To qualify for a given type of decision making, **two of the three elements ... must be either met or exceeded.**” A review of the submitted documentation supports that this component of CPT Code 99213 was not met.

Because only one component of CPT Code 99213 was met, the requestor failed to support the level of service required by 28 Texas Administrative Code §134.203.

5. 28 Texas Administrative Code §129.5 (i) states, in relevant part, “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 ... The amount of reimbursement shall be \$15. (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 total allowable for the disputed charges is \$15.00. The insurance carrier paid \$0.00. Therefore, an additional 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 \$15.00.

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 \$15.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	May 13, 2015
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, 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 MFDR 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 prefriere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.