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
TIMOTHY N. MARKS, MD

Respondent Name
HARRIS COUNTY

MFDR Tracking Number
M4-15-3564-01

Carrier's Austin Representative
Box Number 21

MFDR Date Received
JUNE 26, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary:

"Service Code: 99372

Explanation of Service: Telephone peer to peer conversation."

Charge: $75.00
Reason For Denial. Information does not support his many/frequency of service.
Rational For Payment: This service was a one time service for medical care for this patient. This service was necessary forn [sic] this patient. There was one service and one bill, therefore, the reasoning for non-payment has no validity. Please pay this out standing claim."

Amount in Dispute: $685.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor is seeking reimbursement for dates of service July 31, 2014, and October 6, 2014 in the amount of $685. The allowed reimbursement for the dates of service is $0.00. For procedure codes 99372 and 99354, the provider has billed for peer to peer conversations regarding preauthorization requests made by Dr. Marks. There is no allowable reimbursement for such an action in the Medical Fee Guidelines. Regarding procedure codes 99214 and 99354, the bills were submitted for payment greater than 95 days from the date of service."

Response Submitted By: Thornton, Biechlin, Reynolds & Guerra, L.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 31, 2014	CPT Code 99372 Case Management/Telephone Call	$250.00	$0.00
October 16, 2014	CPT Code 99214 Office Visit	$275.00	$0.00
	CPT Code 99354-25 Prolonged Service	$160.00	$0.00
TOTAL		$685.00	$0.00

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 §134.204 sets out the guidelines for billing and reimbursement of case management services.
4. The services in dispute were reduced / denied by the respondent with the following reason codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 151-Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
   - 29-The time limit for filing has expired.

Issues

1. Does the documentation support billing code 99372?
2. Did the requestor support position that the disputed bill for October 16, 2014 was submitted timely?

Findings

1. The respondent denied reimbursement for CPT code 99372 based upon reason codes "P12" and "151." The respondent states that reimbursement is not due because "For procedure codes 99372 and 99354, the provider has billed for peer to peer conversations regarding preauthorization requests made by Dr. Marks. There is no allowable reimbursement for such an action in the Medical Fee Guidelines."

   28 Texas Administrative Code §134.204(e)(4)(D) states "Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity. Case management services shall be billed and reimbursed as follows: (D) CPT Code 99372. (i) Reimbursement to the treating doctor shall be $46. Modifier "W1" shall be added. (ii) Reimbursement to the referral HCP contributing to this case management activity shall be $12."

   A review of the submitted documentation finds that the requestor did not submit any report to support the case management services and billing of CPT code 99372. As a result, reimbursement is not recommended.

2. According to the explanation of benefits, the respondent denied reimbursement for the services in dispute based upon reason code "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."

   The respondent states "The date of service was October 16, 2014 and the bill was received on April 13, 2015. No known exceptions for late billing apply in accordance with §408.0272."

   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." A review of the submitted documentation does not contain any evidence such as a fax, personal delivery, electronic transmission, or certified green card to support the disputed bill was sent to the respondent.

   The Division finds that the requestor did not submit any documentation to support that the disputed bills were submitted timely in accordance with Texas Labor Code §408.027(a). As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		08/26/2015
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, 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.