**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 and Address**

LONGVIEW OCCUPATIONAL MEDICINE CLINIC
3202 N 4TH STE 100
LONGVIEW TX 75605

**Respondent Name**

HARTFORD UNDERWRITERS INSURANCE

**MFDR Tracking Number**

M4-11-0167-01

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "PT sutured in ER 5-21-10. Per TDI rule 180.22 pt must have a treating MD+ER MD is not a WC MD. Dr. Wells saw pt for follow up as treating MD. Payt should be made for this initial visit by Dr. Wells as he is the treating MD + not subject to the multiple procedure rule."

**Amount in Dispute:** $130.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Summary:** Carrier acknowledged DWC-60 on September 16, 2010. No response submitted.

**Response Submitted by:** Hartford Underwriters Insurance Company.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| May 25, 2010 | 99203 | $130.00 | $130.00 |

## *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. Former 28 Texas Administrative Code §133.307, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, sets out the procedures for resolving medical fee disputes filed prior to June 1, 2012.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for E/M services.

Explanation of benefits

- *45 (45) Charges exceed your contracted/legislated fee arrangement.
- *59(59) Processed based on multiple or concurrent procedure rules..
- *BL To avoid duplicate bill denial. For all recon/adjustments/additional pymnt requests, submit a copy of this EOR or clear notation that a rec.

## Issues

1. Did the requestor meet the requirements of 28 Texas Administrative Code §134.203?
2. Is the requestor entitled to reimbursement?

## Findings

1. 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 99203 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: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or 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 moderate to high severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.

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

   - Documentation of the Detailed History
     - History of Present Illness (HPI) consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions. Documentation found listed five elements thus meeting component.
     - Review of Systems (ROS) requires two to nine systems to be documented. Documentation found listed seven systems, this component was met.
     - Past Family, and/or Social History (PFSH) require at least one specific item from any three history areas to be documented. The documentation found listed one element. This component was met.

   - Documentation of the Detailed Examination
     - Requires at least six organ systems to be documented, with at least two elements per listed system. The documentation found listed seven systems. This component was met.

   The division concludes that the documentation sufficiently supports the level of service billed.

2. For the reasons stated above, the services in dispute are eligible for payment. The Maximum Allowable Reimbursement (MAR) for the services is dispute may be calculated pursuant to 28 Texas Administrative Code §134.203 (c) as follows: (54.32 / 35.8228)*$102.90 = $156.03. The total allowable is $156.03, the carrier paid $0.00. The requestor is disputing payment in the amount of $130.00; therefore $130.00 is the amount recommended for payment.

## 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 $130.00.

## *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 $130.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| | | |
|---|---|---|
| | | February 25 ,2014 |
| Signature | Medical Fee Dispute Resolution Officer | 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**.

**or de llamar a 512-804-4812**.