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

DR SHAHID H SYED MD
PO BOX 31143
TAMPA FL 33631

Respondent Name

INDEMNITY INSURANCE CO OF NORTH

MFDR Tracking Number

M4-11-0208-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The denial EOB does not provide our facility with any explanation as to why. Therefore does not give us an avenue to properly seek reimbursement for services we provided."

Amount in Dispute: $315.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Carrier acknowledged DWC-60 on September 21, 2010.

Response Submitted by: Indemnity Insurance Co of North America

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 14, 2009	99205 & 99080	$315.00	$15.00

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.
3. 28 Texas Administrative Code §129.5 sets out medical bill submission requirements and reimbursement amounts for Work Status reports.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 16- Claim/service lacks information which is needed for adjudication at least one remark code must be provided (May be comprised of wither the remittance advice remark code or ncpdp reject reason code).
- (855-051) Medical documentation does not support and/or justify the submitted charges. $0.00
- 45- Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use group codes PR or CO depending upon liability)..

- 100 – Any network reduction is in accordance with the networkreference above.
- (113-001) Network import re-pricing-contracted provider.
- A1- Claim/service denied. At least one remark code must be provided (may be comprised of either the remittance advice remark code of NCPDP reject reason code.).
- (942-003) Body part mismatch.
- ***99205 is not supported by the notes provided. Please provide additional documentation or re-code.

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 99205 is:

   > Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive 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, 60 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 Comprehensive 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 two chronic conditions, this component was not met.
     - Review of Systems (ROS) inquires about the system (s) directly related to the problem(s) plus additional body systems. At least ten organ systems must be reviewed. Documentation found listed four systems, this component was not met.
     - Past Family, and/or Social History (PFSH) requires a review of two or all history areas, at least one specific item from each history areas to be documented. The documentation found listed two areas. This component was met.
   - Documentation of a Comprehensive Examination:

     Requires at least nine organ systems to be documented, with at least two elements listed per system. The documentation found listed four body/organ systems. This component was not met.

2. Documentation requirements were not met, no additional reimbursement can be recommended for 99205. The division notes that code 99080 was listed on the table of disputed services. Documentation found supports that code 99080 is eligible for payment pursuant to 28 Texas Administrative Code §129.5 .

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement for code 99080 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

		February , 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.