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

Q THAI NGUYEN DC
4151 SW FREEWAY NO 750
HOUSTON TX 77027

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-12-1244-01

MFDR Date Received
December 22, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CCH REPORT COMPENSABLE INJURY CCH REPORT COMPENSABLE INJURY."

Amount in Dispute: $270.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed cpt code 99214 for two E&M episodes on 5/17/11 and 5/24/11. The documentation of those episodes does not correlate with code 99214, which requires 2 of 3 of the following components- detailed history, detailed exam, and decision-making of moderate complexity. What is documented is a problem-focused history, an expanded problem-focused exam, and straight forward decision-making. The requestor billed code 99080-73 for dates 5/17/11 and 5/24/11. Comparing the previous DWC-73 of 4/14/11 with the one of 5/17/11 shows no change warranting notification and payment."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 17 and 24, 2011	99214	$270.00	$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 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

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

- CAC-150 PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE.
- CAC-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).
- 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
- 890– DENIED PER AMA CPT CODE DESCRIPTION FOR LEVEL OF SERVICE AND/OR NATURE OF PRESENTING PROBLEMS.
- 248 – DWC-73 IN EXCESS OF THE FILING REQUIREMENTS; NO CHANGE IN WORK STATUS AND/OR RESTRICTIONS; REIMBURSEMENT DENIED PER RULE 129.5
- CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

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 99214 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, 25 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 one chronic condition, thus not meeting this component.
     - Review of Systems (ROS) requires two to nine systems to be documented. Documentation found no listed systems, this component was not met.
     - Past Family, and/or Social History (PFSH) requires at least one specific item from any three history areas to be documented. The documentation found listed none. This component was not met.
   - Documentation of a Detailed Examination:
     - Requires at least six organ systems to be documented, with at least two elements per listed system. The documentation found listed one body/organ systems: Back, including spine. This component was not met.

   The division concludes that the documentation does not sufficiently support the level of service billed.

2. The carrier denied the disputed service as 248 – "DWC-73 IN EXCESS OF THE FILING REQUIREMENTS; NO CHANGE IN WORK STATUS AND/OR RESTRICTIONS; REIMBURSEMENT DENIED PER RULE 129.5". Review of submitted documentation finds DWC FORM-73, dated 5/17/2011, shows this was not the initial examination of the injured worker for this condition and there was no change in work status or a substantial

changed in activity restrictions. Requestor submitted a medical claim dated 5/24/2011 yet no medical records or DWC FORM-73 for this date of service was found. Therefore, no additional payment can be recommended.

3. For the reasons stated above, the services in dispute are not eligible for payment pursuant to 28 TAC §134.203 (c).

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 $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

		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.