



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
BODIES IN BALANCE

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-12-3153

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JUNE 19, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Attached cch letter with compensability, also attached appeal of peer review, patient continue on need of medical care, she is pending surgical procedure, please review your records and process our bills, please sent payment."

Amount in Dispute: \$540.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Attached is an EOB dated July 11, 2011, showing payment for these services."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 5, 2011 October 7, 2011	CPT Code 99214 Office Visit	\$120.00/ea	\$0.00
November 7, 2011 December 2, 2011	CPT Code 99080-73 Work Status Report	\$15.00/ea	\$0.00
TOTAL		\$540.00	\$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. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets out medical fee guidelines for workers' compensation specific services.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
4. 28 Texas Administrative Code §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CX29-Not medically necessary.
 - CX49-Untimely submission of bill.
 - W1-Workers compensation state fee schedule adjustment.
 - 217-Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.

Issues

1. Does a medical necessity issue exist in this dispute?
2. Does the documentation support billing code 99214? Is the requestor entitled to reimbursement?
3. Does the documentation support billing code 99080-73? Is the requestor entitled to reimbursement?

Findings

1. According to the original explanation of benefits, the respondent initially denied reimbursement based upon not medically necessary. Upon reconsideration, the respondent did not maintain the denial and recommended payment based upon the fee guideline.

The Division contacted the requestor on three occasions between November 27, 2012 and January 8, 2013 to verify payment was received and if services remained in dispute. At the time of review, the requestor had not confirmed that payment was received for the disputed services; therefore, the disputed services will be reviewed per Division fee guidelines.

2. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

CPT code 99214 is defined as "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."

A review of the submitted medical report does not support the documentation requirement which require at least 2 of the 3 key components for code 99214. As a result, reimbursement is not recommended.

3. CPT code 99080-73 is defined as "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form."

28 Texas Administrative Code §134.204 (l) states "The following shall apply to Work Status Reports. When billing for a Work Status Report that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section, refer to §129.5 of this title (relating to Work Status Reports)."

28 Texas Administrative Code §129.5(i)(1) states "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 or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be \$15. A doctor shall not bill in excess of \$15 and shall not bill or be entitled to reimbursement for a Work

Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (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."

28 Texas Administrative Code §129.5 (d)(1) and (2) states "The doctor shall file the Work Status Report: (1) after the initial examination of the employee, regardless of the employee's work status;

(2) when the employee experiences a change in work status or a substantial change in activity restrictions."

A review of the submitted work status report finds that the claimant did not have a change in work status to support billing per 28 Texas Administrative Code §129.5 (d)(2); therefore, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that 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

Signature

Medical Fee Dispute Resolution Officer

Date

11/19/2015

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.