**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**
DAVID RABBANI

**Respondent Name**
NEW HAMPSHIRE INSURANCE CO

**MFDR Tracking Number**
M4-13-1055-01

**Carrier's Austin Representative Box**
Box Number 19

**MFDR Date Received**
December 28, 2012

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Based on this E.O.B. the medical bill of $306.64 for the procedural code 99205 was denied. The rational for the reduction was "Diagnosis was invalid for the dates of service reported. The submitted diagnosis was 959.7 (injury to the knee, leg, ankle & foot). The E.O.B. clearly demonstrates that the accepted diagnosis is 959.9 (Injury to the lower extremity unspecified). "

**Amount in Dispute:** $306.64

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Summary:** No response submitted.

**Response Submitted by:** New Hampshire Insurance Company

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| September 25, 2012 | 99205 | $306.64 | $306.64 |

## *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 a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for E/M services
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - *14 (146) Diagnosis was invalid for the date(s) of service reported.
   - *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. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on January 3, 2013. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

   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, 45 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 six elements, thus meeting this component.
     - 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 12 systems, this component was 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 ten body/organ systems. This component was met.

2. For the reasons stated above, the services in dispute are eligible for payment pursuant to 28 TAC §134.203 (c) as follows: (54.86 / 34.0376)*$190.46 = $306.97. The amount in dispute is $306.64; therefore, the amount recommended for reimbursement is $306.64.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $306.64.

## *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 $306.64 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| | | |
|---|---|---|
| | | June 18, 2014 |
| 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**.