



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

ELITE HEALTHCARE NORTH DALLAS

**Respondent Name**

AMERICAN ZURICH INSURANCE CO

**MFDR Tracking Number**

M4-13-2544-01

**Carrier's Austin Representative Box**

Box Number: 19

**MFDR Date Received**

JUNE 6, 2013

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "THIS PATIENT WON DISTRICT COURT!! I HAVE ATTACHED THE RESULTS... And lastly, date of service 6/12/12 was never reviewed. Per RULE 133.20, I have printed the original bill showing it was filed timely."

**Amount in Dispute:** \$578.74

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "**Late filing as to DOS:** The provider's request was not datestamped as received by DWC MRD until 6/6/13. Consequently, it is not timely as to the DOS prior to 6/6/12 per Rule 133.307(c). The provider has failed to invoke the jurisdiction of DWC MRD as to these dates."

**Response Submitted by:** FLAHIVE, OGDEN & LATSON

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 4, 2009 March 10, 2009 October 27, 2009 January 27, 2010 July 28, 2011 August 2, 2011	Office Visit – CPT Code 99205 Physical Therapy Services Office Visit – CPT Code 99214 Physical Therapy Services Office Visit – CPT Code 99213 Office Visit – CPT Code 99213	\$449.49	\$0.00
June 12, 2012	Office Visit – CPT Code 99213 CPT Code 99080 – Status Report	\$129.25	\$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. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional services.
3. 28 Texas Administrative Code §129.5 sets out the procedures for Work Status Reports.

2. The services in dispute were reduced/denied by the respondent with the following reason codes:
- EOBs were not submitted for eligible date of service June 12, 2012.

### **Issue**

1. Did the requestor submit an amended DWC-60?
2. Did the requestor waive the right to medical fee dispute resolution?
3. Did the requestor support the office visit for date of service June 12, 2012?
4. Did the requestor support the Work Status Report for date of service June 12, 2012?

### **Findings**

1. The requestor submitted an amended table of disputed services on August 12, 2013.
2. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute. (B) A request may be filed later than one year after the date(s) of service if: (i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability." The requestor submitted a copy of the District Court decision. Review of the District Court decision finds that the date the decision was signed was July 9, 2012, sixty (60) days after the District Court decision is August 8, 2012. Medical Fee Dispute Resolution received the request for medical fee dispute resolution on June 6, 2013; therefore dates of service March 10, 2009 through August 2, 2011 were not submitted timely and the requestor has waived the right to Medical Fee Dispute Resolution for those dates of service. Date of service June 12, 2012 is the only date that is considered timely and eligible for review.
3. 28 Texas Administrative Code §134.203(b)(1) states: 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; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules. The disputed issue is an office visit, CPT Code 99213, which 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: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and 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 low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family." Review of the documentation submitted for this date of service finds the service does not support this level of office visit. There is no expanded problem focused history or problem focused examination. Therefore, reimbursement is not recommended.
4. 28 Texas Administrative Code §129.5(d)(2) states: "The doctor shall file the Work Status Report: (2) when the employee experiences a change in work status or a substantial change in activity restrictions;" Review of the Work Status Report finds that the injured workers was released to return to work as of June 12, 2012 with restrictions. 28 Texas Administrative Code §129.5(i) 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." Therefore, reimbursement is recommended in the amount of \$15.00.

**Conclusion**

The Division finds that the requestor has waived the right to medical fee dispute resolution for the dates of service February 4, 2009 through August 2, 2011 and the Division finds that the requestor has established that additional reimbursement is due for date of service June 12, 2012. 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**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
May 13, 2014  
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.**