



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

ELITE HEALTHCARE FORT WORTH

Respondent Name

NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number

M4-13-3263-01

Carrier's Austin Representative

BOX NUMBER: 19

MFDR Date Received

AUGUST 9, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is an approved case and all other dates of service have been paid in full. Claims before and after these dates of service have been paid in full."

Amount in Dispute: \$116.01

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "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 August 19, 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."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 14, 2013	99213-25	\$116.01	\$116.01

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 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:

- 1 – (150) – Payer deems the information submitted does not support this level of service.
- 1 –Documentation does not support level of service billed.

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 respondent denied the service using denial code “1 – (150) –Payer deems the information submitted does not support this level of service and 1 “–Documentation does not support level of service billed.” Review of the documentation submitted finds that the respondent did not support their denial reasons. Therefore, the disputed date of service will be reviewed in accordance with 28 Texas Administrative Code §134.203.

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 99213 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: 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.

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 Expanded Problem Focused History
 - History of Present Illness (HPI) consists of one to three elements of the HPI. Documentation found listed three chronic conditions, thus this component was met.
 - Review of Systems (ROS) inquires about the system directly related to the problem(s) identified in the HPI. Documentation found three systems: constitutional, musculoskeletal, and psychiatric. This component was met.
 - Past Family, and/or Social History (PFSH) are not applicable.
 - Documentation of a Expanded Problem Focused Examination:
 - Requires limited examination of the affected body area or organ system. The documentation found examination of four systems: each extremity, constitutional, musculoskeletal, and psychiatric. This component was met.
2. For the reasons stated above, the services in dispute support the criteria for this level of office visit; therefore, reimbursement is recommended as follows: $(55.30 \div 34.023) \times \$71.61 = \$116.39$. The requestor is seeking \$116.01; therefore, reimbursement in the amount of \$116.01 is recommended.

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 \$116.01.

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 \$116.01 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	October 20, 2014 Date
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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.