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 HEATHCARE FORT WORTH

Respondent Name
TEXAS MUTUAL INSURANCE CO.

MFDR Tracking Number
M4-14-0756-01

Carrier's Austin Representative
BOX NUMBER: 54

MFDR Date Received
NOVEMBER 4, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Patient was seen by the treating provider to see how the patient was progressing during chronic pain management program. Office visits are recommended as determined to be medically necessary."

Requestor's Response to the Respondent's Position Summary, dated December 4, 2013: "In response to the fax that I received from Texas Mutual – Richard Ball. Regarding this dispute for this patient, office visits are to be paid in full. Terating provider meets with the patient to see the progress of the patient while being in the chronic pain management program. I agree with the no payment of work status form 73. With that said, the office visits should be paid in full."

Amount in Dispute: $247.78

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor provided E/M services as part of the comprehensive pai management program and then billed Texas Mutual code 99213-25 for both dates. Texas Mutual reviewed the documentation of the E/M notes and concluded the content of the E/M service appears to be totally related to the claimant's performance and function in the pain management program. The use of the -25 modifier does not appear justified. No payment was made for this. The requestor billed code 99080 for a DWC-73. However, there was no change in the work status report to justify the billing. No payment was made for this either."

Response Submitted by: TEXAS MUTUAL INSURANCE CO.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 18, 2013 July 24, 2013	CPT Code 99213-25	$232.78	$0.00
July 24, 2013	CPT Code 99080-73	$15.00	$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 §134.203 sets out the reimbursement guidelines for E/M services.
3. 28 Texas Administrative Code §129.5 sets out the procedures for submitting Work Status Reports.

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

- 193 – Original payment decision is being maintined. Upon review, it was determined that this clalim was processed properly.
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 217 – The value of this procedure is included in the value of another procedure performed on this date.
- 854 – Modifier -25 billed. Documentation does not support a significant, sepaaretely identifiable E&M service.
- 891 – No additional payment after reconsideration.

Issues

1. Did the requestor meet the requirements of 28 Texas Administrative Code §134.203?
2. Did the requestor meet the requirements of 28 Texas Administrative Code §129.5
3. 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 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: 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 conditions, thus meeting this component.
     - Review of Systems (ROS) requires two to nine systems to be documented. Documentation found listed two systems, this component was 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 no areas listed. 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 1 body/organ system: muscoskeletal. This component was not met.
- The respondent denied the office visits using denial codes 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated" and 271 – The value of this procedure is included in the value of another procedure performed on this date." Review of the respondents documentation finds that the denial codes are not supported.
- The Requestor also attached modifier -25 to the office visits. This modifier is defined as "Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service." Review of the office visits notes finds insufficient documentation to support the use of the modifier.

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

2. In accordance with 28 Texas Administrative Code §129.5(d)(2), the doctor shall file the Work Status Report when the employee experiences a change in work status or a substantial change in activity restrictions. The requestor submitted a response to the respondents position summary stating, "I agree with the no payment of the work status form 73." Since the requestor agrees with the no payment of the Work Status Report. Reimbursement is not recommended.

3. For the reasons stated above, the services in dispute are not eligible for payment.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is not 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	June 23, 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.