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 GARLAND

Respondent Name
FIDELITY & GUARANTY INSURANCE

MFDR Tracking Number
M4-14-1166-01

Carrier's Austin Representative
BOX NUMBER: 19

MFDR Date Received
December 27, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Office Visit for the attached date of service, 02/15/2013, has been denied due to "CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.' Per ODG office visits are recommended to be medically necessary. They are used to give proper diagnosis and return to function of and [sic] injured worker. The need for trhese vists with a healthcare provider are based upon a review of patient concerns, signs and symptoms and should be monitored on a regular bases. (SEE ATTACHED). The doctor addressed Patient's pain level, and noted that the signs and symptoms were same as last Office Visit. The doctor refered the pt for CPM and Psychologic Evaluation which is necessary to determine further treatment options. This date of service should have been paid in full. I have attached all necessary documentation for your review."

Amount in Dispute: $118.83

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 January 7, 2014. 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 15, 2013	99213-25	$118.83	$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. Former 28 Texas Administrative Code §133.307, 33 *Texas Register* 3954, applicable to requests filed on or

after May 25, 2008, sets out the procedures for resolving medical fee disputes filed prior to June 1, 2012
2. 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:

- BL – This bill is a reconsideration of a previously reviewed bill. Allowance amounts do not reflect previous payments.
- 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing
- 16 – Claim/service lacks information which is needed for adjudication.

Issues

1. Did the requestor meet the requirements of 28 Texas Administrative Code §134.203?
2. 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: 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 one chronic condition, 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 a review of one system. 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 and other symptomatic or related organ system(s). The documentation found examination of one system. This component was not met.

   The requestor attached modifier -25 to CPT Code 99213. Modifier -25 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 visit note finds insufficient documentation to support the use of the modifier.

2. For the reasons stated above, the services in dispute do not support the office visit and reimbursement is not 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	July 22, 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.