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
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-14-1168-01

Carrier's Austin Representative Box
Box Number 54

MFDR Date Received
December 27, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Office Visit for the attached date of service, 06/13/2013, has been denied due to"PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE. Per ODG office visits are medically necessary to evaluate the proper diagnosis and return to function of and injured worker. The need for these visits with a healthcare provider are based upon review of patient concerns, signs and symptoms and should be monitored on a regular basis. (SEE ATTACHED) This date of service should have been paid in full. I have attached all necessary documentation. Please kindly help us get these dates of services paid."

Amount in Dispute: $119.22

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual maintains its position the requestor's E and M service is so poorly documented it does not meet the usage criterion of the -25 modifier. No payment is due."

Response Submitted by:

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 13, 2013	99213	$119.22	$0

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
   - CAC-150- Payer deems the information submitted does not support this level of service.
   - CAC-193- Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

- 864- E/M services may be reported only if the patient's condition requires a significant separately 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. 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 History
     - History of Present Illness (HPI) consists of one to three elements of the HPI. Documentation did not find any elements listed. This component was not met.
     - Review of Systems (ROS) inquires about the system directly related to the problem(s) identified in the HPI. Documentation did not find any elements listed. This component was not met.
     - Past Family, and/or Social History (PFSH) are not applicable.
   - Documentation of a Expanded Examination:
     - Requires limited examination of the affected body area. Documentation did not find any elements listed. This component was not met.

2. For the reasons stated above, the services in dispute for service date June 13, 2013 is not eligible for payment pursuant to 28 TAC §134.203 (c).

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional 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

		July 31, 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.