



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

ELITE HEALTHCARE FORT WORTH

Respondent Name

PRAETORIAN INSURANCE CO

MFDR Tracking Number

M4-14-1456-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

JANUARY 27, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These bills were previously submitted in a timely manner. Please review the attached documentation and pay according to the TDI guidelines."

Amount in Dispute: \$262.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per Nurse Review: The medical record only supports a 99203. A 99204 requires 10+ Review of Systems, the medical record does not have anywhere close to the 10+ ROS. CV had no choice but to recommend a lower level. The correct recommended level would be 99203. The provider would have to resubmit corrected billing with the level code 99203 to be due additional money."

Response Submitted by: GALLAGHER BASSETT SERVICES, INC.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: October 1, 2013, Office Visit, \$262.90, \$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:

- 15 – (150) Payer deems the information submitted does not support the level of service.

- BL – This bill is a reconsideration of a previously reviewed bill. Allowance amounts do not reflect previous payments.

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 a new patient. The American Medical Association (AMA) CPT code description for 99204 is:

Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive 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, 45 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 no chronic conditions and three elements, neck, back and bilateral knee regions, thus, this component was not met.
 - Review of Systems (ROS) requires 10 or more systems or the pertinent positives and/or negatives of some systems with a statement “all other negative”. Documentation found listed one system, musculoskeletal, thus, this component was not met.
 - Past Family, and/or Social History (PFSH) requires at least two or three history areas to be documented. The documentation found listed no areas. This component was not met.
 - Documentation of a Detailed Examination:
 - Requires general multi-system exam (8 or more systems) or a complete exam of single organ system. The documentation found listed 4 body area/organ systems: neck, back and bilateral knee regions. This component was not met.
2. The division concludes that the documentation does not sufficiently support the level of service billed and reimbursement is not recommended.

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

Signature

Medical Fee Dispute Resolution Officer

July 31, 2015
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 MFDR 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.