



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 NORTH DALLAS

Respondent Name

HARTFORD UNDERWRITERS INSURANCE

MFDR Tracking Number

M4-14-1518-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

JANUARY 27, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "PER TDI REQUIREMENTS, and office visit MUST be billed with work status reports for the time taken to complete them. Please see attached rule. Therefore these claims should be PAID IN FULL to prevent IRO... and MFDR..."

Amount in Dispute: \$119.22

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier upholds denial of CPT 99213 25 as per our review documentation submitted with billing does not support the CPT 99213 criteria: *An expanded problem-focused history, an expanded problem-focused examination, and medical decision making of low complexity.*"

Response Submitted by: THE HARTFORD

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 24, 2013	CPT Code 99213-25	\$119.22	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
 - 589 – The documentation received does not support the level of service billed. Please adjust the level of service billed or provide additional documentation to support the service billed.
 - 247 – A payment or denial has already been recommended for this service.
 - B12 – Previously paid. Payment for this claim/service may have been provided in a previous payment.

Issues

1. Did the requestor support the level of services provided?
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 no chronic conditions, thus this component was not met.
 - Review of Systems (ROS) inquires about the system directly related to the problem(s) identified in the HPI. Documentation was not found. This component was not 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 did not support an examination of the affected body area was done. Therefore, 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.

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

2. For the reasons stated above, the services in dispute do not support the criteria for this level of 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

June 27, 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.