



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

Mike Shah MD PA

Respondent Name

Texas Mutual Insurance

MFDR Tracking Number

M4-14-1816-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

February 21, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Dr. Shah met at least two of the three components that were required... Texas Mutual continues to deny the claim because the auditor feels we have not met the minimum requirements."

Amount in Dispute: \$350.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 2/5/13 and 5/28/13. In order to resolve this fee reimbursement dispute over code 99214 Texas Mutual Insurance Company has elected to pay the disputed services."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 5, 2013 and May 28, 2013	99214, G0434	\$350.44	\$166.17

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 reimbursement guidelines for professional medical services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 150 – Payer deems the information submitted does not support this level of service
 - 16 – Claim/service lacks information which is needed for adjudication
 - 193 – Original payment decision is being maintained

Issue

- Did the requestor waive the right to medical fee dispute resolution?

2. Did the requestor support the level of service billed for date of service May 28, 2013?
3. What is the applicable rule pertaining to reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the services in dispute is February 5, 2013. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on February 21, 2013. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.
2. The carrier denied the disputed service as, 150 – "Payer deems the information submitted does not support this level of service." 28 Texas Administrative Code §134.203 (b) 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; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules." Review of the submitted medical bill finds;
 - Disputed service 99214 is described as: 99214 – 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.
 - Review of the medical record finds;
 - i. History – Documentation to support 3 conditions, documentation support 5 elements of present illness, documentation supports one past medical history. Requirements of detailed evaluation and management code met.
 - ii. Examination – Documentation supports a combination of 7 system/areas. Requirements of detailed evaluation and management code met.
 - iii. Medical decision – Documentation supports straight-forward complexity.The Division finds the required elements of the submitted code are supported. Therefore, the carrier's denial is not supported. The service in dispute that was submitted to MFDR timely will be reviewed per applicable rules and fee guidelines.
3. 28 Texas Administrative Code §134.203 (c) states in pertinent part, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor)." The maximum allowable reimbursement will be calculated as follows;
 - Procedure code 99214, service date May 28, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 1.5 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 1.5135. The practice expense (PE) RVU of 1.54 multiplied by the PE GPCI of 1.017 is 1.56618. The malpractice RVU of 0.1 multiplied by the malpractice GPCI of 0.834 is 0.0834. The sum of 3.16308 is multiplied by the Division conversion factor of \$55.30 for a MAR of \$174.92.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute, as addressed in 28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A). For that reason, the merits of the issues raised by the parties to this dispute have not been addressed for dates of service February 5, 2013.

The total allowable reimbursement for the service eligible for review (May 28, 2013) is \$174.92. The amount previously paid by the insurance carrier is \$0.00. The requestor is seeking additional reimbursement in the amount of \$166.17. This amount is recommended. While the carrier stated in their position statement, "In order to resolve this fee reimbursement dispute over code 99214 Texas Mutual Insurance Company has elected to pay the disputed services." No evidence was found to support such a payment was made. As a result, the amount ordered is \$166.17.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$166.17, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature


Signature

Peggy Miller
Medical Fee Dispute Resolution Officer

February 17, 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 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.