



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

ELITE HEALTHCARE GARLAND

**Respondent Name**

ARCH INSURANCE CO

**MFDR Tracking Number**

M4-14-2032-01

**Carrier's Austin Representative Box**

Box Number 19

**MFDR Date Received**

MARCH 10, 2014

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The Office Visits for the attached date of service, 09/05/2013, and 09/30/2013, has been denied due to "PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE." Per ODG Guidelines it is necessary for the doctor to evaluate and treat the patient to provide a plan of care."

**Amount in Dispute:** \$378.90

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Summary:** "Nurse review looked through the documentation and we still agree with the denials. It appears that maybe the provider is filling out the forms but the writing is so light and illegible that Nurse Review cannot tell what is written, circled, etc. Nurse Review wouldn't be able to recommend any additional allowances without more complete documentation from the provider."

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 5, 2013	99204	\$259.68	\$0
September 30, 2013	99213	\$119.22	\$0
Total		\$378.90	\$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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute
- 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:

Explanation of benefits

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

payments.

- \*15- (150) Payer deems the information submitted does not support this level of service
- \*W3- (W3) Request for reconsideration.
- \*LN- This line was included in the reconsideration of this previously reviewed bill.
- BL- After review of the bill and the medical record, this service is best described by code 99202. Submitted documentation did not meet the key components required for 99204.
- RL- The charge was reviewed through the clinical validation program.
- BL- To avoid duplicate bill denial. For all recon/adjustment/additional pymnt requests, submit a copy of this EOR or clean notation that a recon is requested.

### 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 **99204 for service date September 5, 2013:**

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.

28 Texas Administrative Code §133.307(c) states “Requests. Requests for MFDR shall be filed in the form and manner prescribed by the division. Requestors shall file two legible copies of the request with the division.” Review of the documentation submitted finds that the office visit note is illegible. Therefore, no reimbursement can be established and is not recommended.

The American Medical Association (AMA) CPT code description for **99213 for service date September 30, 2013:**

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.

28 Texas Administrative Code §133.307(c) states “Requests. Requests for MFDR shall be filed in the form and manner prescribed by the division. Requestors shall file two legible copies of the request with the division.” Review of the documentation submitted finds that the office visit note is illegible. Therefore, no reimbursement can be established and is not recommended.

2. For the reasons stated above, the services in dispute for service dates September 5, 2013 through September 30, 2013 are 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**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
Date

July , 2014

***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.**