



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

CHANNELVIEW MEDICAL CENTER

Respondent Name

OLD REPUBLIC GENERAL INSURANCE

MFDR Tracking Number

M4-14-2033-01

Carrier's Austin Representative Box

Box Number 44

MFDR Date Received

March 10, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We received response from the carrier's representative stating that the bill was denied based upon the required OB qualifier missing in box 24I. Until this response, we were not given a clear rationale as to why the bill was denied and yet all other bills missing this qualifier have been reviewed and paid."

Amount in Dispute: \$165.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Coventry stands by its review. F090 set to verify if the rendering line provider license qualifier OB is missing or invalid.... OB qualifier was not listed in 24I."

Response Submitted by: Flahive, Ogden & Latson.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 19, 2013	99213	\$165.10	\$118.65

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

- Former 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 E/M services

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- *16- (16) Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- *BL- To avoid duplicate bill denial. For all recon/adjustments/additional pymnt requests, submit a copy of this EOR or clear notation that a rec

Issues

- 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 found listed four elements, thus meeting component.
 - Review of Systems (ROS) inquires about the system directly related to the problem(s) identified in the HPI. Documentation found listed five systems. This component was met.
 - Past Family, and/or Social History (PFSH) are not applicable.
- Documentation of a Expanded Examination:
 - Requires limited examination of the affected body area or organ system. The documentation found examination of five systems. This component was met

The division concludes that the documentation sufficiently supports the level of service billed.

2. For the reasons stated above, the services in dispute are eligible for payment pursuant to 28 TAC §134.203 (c) as follows: $(55.30 / 34.023) * \$73.00 = \118.65

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$118.65.

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 \$118.65, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

July , 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.