**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 GARLAND

**Respondent Name**
CONTINENTAL CASUALTY CO

**MFDR Tracking Number**
M4-14-2128-01

**Carrier's Austin Representative Box**
Box Number 47

**MFDR Date Received**
March 17, 2014

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:**"The office visit (re-evaluation) for the attached date of service 12/05/2013, has been denied due to "PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE." The doctor reviewed Operative Report as well as MRIs with the patient. The doctor also discussed pain level which was worse therefore no physical exam could be performed and requesting an EMG to further evaluate patient's pain. I have resubmitted this request to the carrier and they are still denying payment."

**Amount in Dispute:** $174.92

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:**" The provider is disputing the payment allowance of zero. The Carrier contends that the HCP has not met the AMA CPT guidelines for the CPT 99214 as billed."

**Response by:** Law Offices of Brian J. Judis.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| December 5, 2013 | 99214 25 | $174.92 | $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**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for E/M services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 1- (150) Payer deems the information submitted does not support this level of service.
   - 2- (W1) Workers compensation state fee schedule adjustment.
   - 1- CV: The level of E&M code submitted is not supported by documentation. (V122).
   - 2- Line paid at 100 percent of billed charges. (P304).

- 3- Physical medicine-chiropractic services rendered beyond $5,000.00 since DOI. (MT02).
- 4- Physical medicine-chiropractic services rendered beyond 90 days from DOI. (MT02).
- 3- Physical medicine chiropractic services rendered beyond 90 days from DOI. (MT04)
- 4- Physical medicine chiropractic services rendered beyond 15 visits since DOI.
- 3- (W3) Request for reconsideration.
- 4- (1930 Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 1- CV: The level of E&M code submitted is not supported by documentation. (V122).
- *- After review of the bill and the medical record, this service is best described by code 99212. Submitted documentation have been re-evaluated by clinical validation. Submitted documentation does not support an additional allowance. (Z257).
- *-CV reconsideration no additional allowance recommended. This bill and submitted documentation have been re-evaluated by clinical validation. Submitted documentation does not support an additional allowance. (Z257).
- *We are unable to recommend an additional allowance since the claim was paid in accordance with the state's fee schedule guidelines. First Health bill review's usual and customary policies, and/or was reviewed in accordance with the provider's contract with First Health.

**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 99214 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: 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.

   - 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 one element, this component was not met.
     - Review of Systems (ROS) requires two to nine systems to be documented. Documentation found listed one element, this component was not met.
     - Past Family, and/or Social History (PFSH) requires at least one specific item from any three history areas to be documented. The documentation found listed no areas. This component was not met.
   - Documentation of a Detailed Examination:
     - Requires at least six organ systems to be documented, with at least two elements per listed system. The documentation found one body/organ systems. This component was not met.

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

2. For the reasons stated above, the service in dispute is 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**

| | Greg Arendt | August 1, 2014 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Officer | 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.