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
Jack L. Deetjen, MD

Respondent Name
Trumbull Insurance Company

MFDR Tracking Number
M4-15-0867-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
November 10, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are disputing the non payment of procedure code 99213 in the amount of $95.00. The carrier denied the procedure code stating the procedure was not provided to the patient. We have appealed it with a copy of the chart visit note. They have denied it again for the same reason."

Amount in Dispute: $95.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "After review, Coventry stands by the denial of the office visit.

Per our Clinical Validation department: At this time, denial remains due to the following:

Provider has billed 99213 for DOS 8/21/14. Medical office report submitted reflects a DOS of 9/9/14. Provider must rebill office notes to correlate the billed charge reflected on the HCFA."

Response Submitted by: Coventry Workers' Comp Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 21, 2014	Established Evaluation & Management (99213)	$95.00	$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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.210 sets out the requirements relating to medical documentation.
3. 28 Texas Administrative Code §133.10 defines the healthcare provider billing procedures relating to forms.
4. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of a medical bill.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 11 – (112) Service not furnished directly to the patient and/or not documented.
   - ZE10 – Code not defined as required in 28 Texas Administrative Code §133.240 (f)(17)(H)

Issues

1. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.307 (c)(2) states in relevant part, "(J) a paper copy of all medical bill(s) related to the dispute, **as originally submitted to the insurance carrier** in accordance with this chapter and **a paper copy of all medical bill(s) submitted to the insurance carrier** for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions)…(M) a copy of **all applicable medical records** related to the dates of service in dispute" [emphasis added].

   Review of the submitted documentation finds that the medical office notes for the services in dispute are not included. Therefore, the requestor has not supported entitlement to reimbursement.

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

	Laurie Garnes	February 11, 2015
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.