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 FORT WORTH

Respondent Name
COMMERCE & INDUSTRY INSURANCE

MFDR Tracking Number
M4-15-0975-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
NOVEMBER 21, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Treating provider, Dr. Lopez has attached dictations outlining key components for these office visits. All of this documentation was sent in for reconsideration to the carrier and claims were still denied."

Amount in Dispute: $391.17

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 14, 2014	CPT Code 99361-W1 Medical Conference	$113.00	$0.00
April 8, 2014	CPT Code 99214 Office Visit	$165.84	$0.00
May 13, 2014	CPT Code 99213 Office Visit	$112.33	$0.00
TOTAL		$391.17	$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 §134.204, effective March 1, 2008, sets out medical fee guidelines for workers' compensation specific services.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for

professional services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1-Workers compensation state fee schedule adjustment.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - VA07-This service/supply is not covered according to the state fee schedule guideline.
   - 16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - VF06-Documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge.
   - F262-The provider's State Billing License Number is Invalid or was not received pursuant to Texas Rule 133.10.
   - 150-Payer deems the information submitted does not support this level of service.
   - W3-Request for reconsideration.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
5. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on November 26, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Issues

1. Did the requestor support billing the medical conference in accordance with 28 Texas Administrative Code §134.204? Is the requestor entitled to reimbursement?
2. Does the documentation support billing code 99214-25? Is the requestor entitled to reimbursement?
3. Does the documentation support billing code 99213-25? Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.204(e)(2) states: "Case Management Responsibilities by the Treating Doctor is as follows: Team conferences and telephone calls should be triggered by a documented change in the condition of the injured employee and performed for the purpose of coordination of medical treatment and/or return to work for the injured employee."

   28 Texas Administrative Code §134.204(e)(4) states "Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity. Case management services shall be billed and reimbursed as follows: (A) CPT Code 99361. (i) Reimbursement to the treating doctor shall be $113. Modifier "W1" shall be added. The requestor billed CPT code 99361-W1.

   Review of the submitted TEAM CONFERENCE report dated March 14, 2014 finds that the requestor listed the participants in the conference; however, the record does not support the treating doctor participated to support billing code 99361-W1 in accordance with 28 Texas Administrative Code §134.204(e)(4)(A)(i). The documentation also does not support that the case management services were triggered by a documented change in the condition of the injured employee and performed for the purpose of coordination of medical treatment and/or return to work for the injured employee. As a result, reimbursement is not recommended.

2. The respondent denied reimbursement for the office visit rendered on April 8, 2014 based upon a lack of documentation.

   28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   On the disputed date of service, the requestor billed CPT codes 97545-WH, 97546-WH, 99214 and 99080-73.

   CPT code 99214 is defined as "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."

A review of the submitted medical report finds that the requestor did not document two of the three key components required for CPT code 99214. As a result, reimbursement is not recommended.

3. According to the submitted explanation of benefits, the respondent denied reimbursement for the May 13, 2014, office visit based upon a lack of documentation.

   CPT code 99213 is defined as "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."

   A review of the submitted medical report finds that the requestor did not document two of the three key components required for CPT code 99213. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that 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	04/10/2015 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.