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
STARR INDEMNITY & LIABILITY CO

MFDR Tracking Number
M4-15-1711-01

Carrier's Austin Representative
Box Number 09

MFDR Date Received
FEBRUARY 9, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Treating provider, Dr. Lopez has attached dictation regarding patient's visit with him. Dr. Lopez has outlined key components regarding patient's visit and discusses future treatment for the patient. All other visits have been paid in full."

Amount in Dispute: $368.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Supplemental response will be provided once the bill auditing company has finalized their review."

Response Submitted By: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 12, 2014	CPT Code 99204-25 Office Visit	$255.04	$0.00
February 14, 2014	CPT Code 99361-W1 Medical Conference	$113.00	$0.00
TOTAL		$368.04	$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:
   - 150-Payer deems the information submitted does not support this level of service.
   - W3-Request for reconsideration.
   - B12-Services not documented in patients medical records.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Does the documentation support billing code 99204-25? Is the requestor entitled to reimbursement?
2. Did the requestor support billing the medical conference in accordance with 28 Texas Administrative Code §134.204? Is the requestor entitled to reimbursement?

Findings

1. 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."

   CPT code 99204 is defined as "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."

   A review of the submitted medical reports finds that the requestor did not document a comprehensive history; therefore, the documentation does not support billing CPT code 99204 on the disputed dates of service. As a result, reimbursement is not recommended.

2. 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; however, the documentation does not support that the treating doctor participated in the case management service.

   Review of the submitted TEAM CONFERENCE report dated February 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.

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

		04/15/2015
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.