



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

Liberty Mutual Insurance Company

MFDR Tracking Number

M4-15-1768-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

February 12, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am resubmitting the claim for payment for the following reasons: THIS IS NOT A DUPLICATE CLAIM/SERVICE. Carrier has paid all other visits for this patient in full. Dr. Lopez has pointed out the correct diagnosis codes for this patient. Office visits are recommended as determined to be medically necessary. All other visits have been paid in full. All of this documentation was sent in for reconsideration to the carrier. This is an approved case with all other claims being paid in full. Please see attached patient account statement showing all other claims being paid in a timely manner. I'm taking the next step to get the rest of these claims paid and sending all documentation I have to MDR. THESE ARE NOT DUPLICATES. All other claims have been paid at 100%. Therefore, these claims should be paid in full."

Amount in Dispute: \$255.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We base our payments on the Texas Fee Guidelines and the Texas Department of Insurance Division of Workers' Compensation Acts and Rules. This is not a network claim.

The office visit of August 8, 2014 was billed as an initial office visit and was denied because it was not the initial visit."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 6, 2014	Evaluation & Management, New Patient (99204)	\$255.04	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the fee guidelines for billing and reimbursing professional medical services.
- 28 Texas Administrative Code §133.240 sets out the procedures for medical bill payments and denials.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
- P12 – Not defined as required in 28 Texas Administrative Code §133.240.
 - M6570 – An initial visit was billed on a subsequent date of service. Resubmit with an appropriate code.
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is the billing of a new patient evaluation and management examination supported for the date of service?
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 billed for an office visit for the evaluation and management of a new patient on behalf of Dr. Michael Lopez.

The American Medical Association (AMA) CPT code description for 99204 is:

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.

Further, the AMA defines a new patient as someone who has “not received professional services from the physician ... in the previous three years.” Review of the submitted documentation finds that Dr. Michael Lopez saw the injured employee on July 10, 2014 and billed for an office visit for the evaluation and management of a new patient through Elite Healthcare Fort Worth. Therefore, the billing of a new patient evaluation and management examination is not supported for the date of service in dispute.

2. Because the requestor did not support the service billed, no further reimbursement is recommended.

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

Signature

Laurie Garnes
Medical Fee Dispute Resolution Officer

March 25, 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.