



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

HOUSTON ORTHOPEDIC AND SPINE

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-15-3188-01

Carrier's Austin Representative

BOX NUMBER: 54

MFDR Date Received

MAY 28, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT Code 99214 was denied by Texas Mutual on 7-1-14 for: payer deems the information submitted does not support this level of service. An appeal was done and included a statement from the coder/biller referencing the AMA CPT Code requirements for CPT Code 99214. Texas Mutual denied the appeal on 5-8-15 upholding the original claim decision."

Amount in Dispute: \$257.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed code 99214 for an E&M service on the date above. The documentation indicates a detailed history, a problem focused exam, and low complex medical decision making. Because this does not meet the criteria for 99214, Texas Mutual declined to issue payment."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: September 23, 2014, 99214, \$257.00, \$159.70

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. Former 28 Texas Administrative Code §133.307, 33 Texas Register 3954, applicable to requests filed on or after May 25, 2008, sets out the procedures for resolving medical fee disputes filed prior to June 1, 2012
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for E/M services

The services in dispute were reduced/denied by the respondent with the following reason codes:

- P12 – Workers’ Compensation Jurisdiction Fee Schedule Adjustment.
- W3, 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 150 – Paymer deems the information submitted does not support his level of service.
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 225 – The submitted documentation does not support the service being billed.
- 725 – Approved non Network provider for Texas Star Network Claimant per Rule 1305.153(C).
- 890 – Denied per AMA CPT Codes description for level of service and/or nature of presenting problems.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 724 – No additional payment after a reconsideration of services.

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.

The 1997 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare policy. It describes the documentation requirements for the service in dispute. Review of the documentation finds the following:

- 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 four chronic conditions, thus meeting this component.
 - Review of Systems (ROS) requires two to nine systems to be documented. Documentation found listed eight systems, this component was 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 one area. This component was met.
- Documentation of a Detailed Examination:
 - Requires extended exam of affected area(s) and other symptomatic or related organ system(s), additional systems up to total of seven systems to be documented. The documentation found listed 5 body area/organ systems: each extremity, constitutional, respiratory, skin, lymphatic, vascular and musculoskeletal. This component was met.

The division concludes that the documentation sufficiently supports the level of service billed.

2. For the reasons stated above, the services in dispute are eligible for payment pursuant to 28 TAC §134.203 (c) as follows: $(55.75 / 35.8228) * \$102.62 = \159.70

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$ 159.70.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$159.70 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 30, 2015 Date
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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. Page 2 of 2