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
Elite Healthcare Fort Worth

Respondent Name
WC Solutions

MFDR Tracking Number
M4-15-3375-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 12, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Treating provider has attached dictation regarding the patient's office visit with him. Dr. Lopez has outlined key components for the visit. All other claims have been paid in full with no discrepancies."

Amount in Dispute: $180.84

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Starr Comprehensive solutions, Inc. maintains the position that the requestor is not eligible for reimbursement of the disputed services."

Response Submitted by: Starr Comprehensive Solutions, Inc., P.O. Box 801464, Houston, TX 77280

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 21, 2014	99214, 99080 -73	$180.84	$15.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §129.5 sets out the requirements for Work Status Reports.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 150 – Payment adjusted because the payer deems the information submitted does not support this level of service.

- 16 – Documentation submitted does not support billed services
- 193 – Original payment decision is being maintained

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Was the rule pertaining to Work Status Reports met?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed service code 99214 with claim adjustment reason code 150 – "Payment adjusted because the payer deems the information submitted does not support this level of service." 28 Texas Administrative Code §134.203 (b) requires that "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;."

   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
     - Review of Systems (ROS) requires two to nine systems to be documented. Documentation found listed one system (musculoskeletal), this component was not met.
     - Past Family, and/or Social History (PFSH) require at least one specific item from any three history areas to be documented. The documentation found listed none. This component was not met.
   - Documentation of a Detailed Examination:
     - Requires at least seven systems to be documented, with at least two elements per listed system. The documentation found listed two, back including spine, musculoskeletal. This component was not met.

   The division concludes that the documentation does not sufficiently support the level of service billed. The carrier's denial is supported. No additional payment can be recommended.

2. 28 Texas Administrative Code §129.5 (d) states, "The doctor shall file the Work Status Report: (1) after the initial examination of the employee, regardless of the employee's work status; (2) when the employee experiences a change in work status or a substantial change in activity restrictions;…" Review of the submitted DWC Form-73 finds a documented change in the status of the injured worker for example;

   - Part II (b) – "will allow the employee to return to work as of 11/21/14 (date) with the restrictions identified in PART III, which are expected to last through 12/04/14 (date)"
   - Part III – "Activity Restrictions, 14. Posture Restrictions Standing 1-2, 17. Motion Restrictions 1 hour"

   The carrier's denial is not supported. This service in dispute will be reviewed per applicable fee guideline.

3. 28 Texas Administrative Code §129 (i) states, "Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15…" The total allowable amount for the services in dispute is $15.00. This amount is recommended.

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 $15.00.

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 $15.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		July 28, 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, 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 MFDR 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.