



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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

TIMOTHY MARKS, MD

Respondent Name

SENTRY CASUALTY CO

MFDR Tracking Number

M4-15-3518-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

June 23, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Rational For Payment: The medical services wwas [sic] performed, billed out timely and down coded to satisfy the IC reasoning for the denial. I resubmitted the claim with a lessor code and fee, and the IC denied for the same reasoning."

Amount in Dispute: \$470.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT 99204 12/30/2014 - Provider billed \$375.00 the providers charge was denied and a payment allowance of zero was issued...The provider has met the comprehensive exam and moderate medical decision making. The history is better described as detailed...CPT 99358 12/30/2014 - Provider billed \$95.00, the providers charges were denied and payment allowance of zero was issued. The provider must document the time spent and content...The provider has not met the CPT requirements for prolonged evaluation and management."

Response Submitted by: Sentry

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Rows include December 30, 2014 with CPT codes 99204 and 99358, and a TOTAL row.

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, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 150-Payer deems the information submitted does not support this level of service.
 - P12-Workers' compensation jurisdictional fee schedule adjustment.
 - B12-Services not documented in patient's medical records.
 - V122-CV: The level of E&M code submitted is not supported by documentation.
 - P300-The amount paid reflects a fee schedule reduction.
 - Z710-The charge for this procedure exceeds the fee schedule allowance.
 - V138-CV: Documentation doesn't support prolonged services.
 - ZV11-After review of the bill and the medical record, this service is best described by 99203. Submitted documentation did not meet the 3 key components required for 99204. Lacking a comprehensive history and a medical decision making of high complexity.
 - W3, ZE10-Request for reconsideration.
 - ZD86-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - Z257-CV reconsideration no additional allowance recommended. This bill and submitted documentation have been re-evaluated by clinical validation. Submitted documentation does not support an additional allowance.

Issues

1. Does the documentation support billing CPT code 99204? Is the requestor entitled to reimbursement?
2. Does the documentation support billing CPT code 99358? Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for CPT code 99204 is denied based upon reason codes "150" and "ZV11."

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 Initial Evaluation report does not support billing CPT code 99204. As a result, no reimbursement is recommended.

2. The respondent denied reimbursement for CPT code 99358 based upon reason codes "B12" and "V138."

CPT code 99358 is defined as "Prolonged evaluation and management service before and/or after direct patient care; first hour."

The requestor wrote "In this case the treating doctor referred this patient for medical care evaluation and treatment. The treating doctor provided me with copies of medical records MRI and/or radiology reports to

correlate with the patient encounter. Such review was a distinct and separate billable service.”

The Division reviewed the report and finds that the requestor did not document the duration of medical records review. The requestor did not document the start and end time of the evaluation and management code 99204, and start and end time of code 99358; therefore, the billing of code 99358 is not supported. As a result, reimbursement is not 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

_____	_____	08/13/2015
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.