



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

Texas Health Center

Respondent Name

American Zurich Insurance Co

MFDR Tracking Number

M4-15-3777-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

July 13, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Dr. Klein performed a detailed history and examination to determine the extent of the injury to both knees and right hip."

Amount in Dispute: \$216.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to the applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 8, 2014	99214	\$216.00	\$0.00

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
- 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
 - W3 – Request for reconsideration

The requestor indicated date of service March 23, 2015 on the DWC 60 submitted with the dispute. However, all documentation contained in the dispute indicates the date of service in dispute to be December 8, 2014. The Division will consider this date of service in the dispute.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 150 – "Payer deems the information submitted does not support this level of service." 28 Texas Administrative Code §134.203(b) states

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; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

The submitted code 99214 has a description of;

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.

Supporting documentation requirements of code are;

- Documentation of the Detailed History
 - Status of chronic conditions: (HPI) the status of at least three chronic or inactive conditions. Documentation found listed three chronic conditions, thus meeting this component.
 - History of Present Illness elements: Extended four or more elements. Documentation found listed one, thus not meeting this component.
 - Review of Systems (ROS) requires two to nine systems to be documented. Documentation found listed four systems, this component was 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 one area. This component was met.
- Documentation of a Detailed Examination:
 - Requires at least six organ systems to be documented, with at least two elements per listed system. The documentation found listed two body/organ systems: body areas – neck and each extremity. Organ systems – Constitutional, respiratory, musculoskeletal. This component was not met.

Insufficient documentation was found to support the required time component was met. The carrier's denial is supported. No additional payment can be recommended.

2. Pursuant to Rule 134.203(b) no additional payment can be recommend. A guide to documentation and coding of evaluation and management CPT codes can be found at, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf.

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	Medical Fee Dispute Resolution Officer	August , 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, 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.