



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 Pain Relief Group

Respondent Name

Texas Mutual Insurance

MFDR Tracking Number

M4-16-0947-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

December 8, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am requesting this review because Texas Mutual is denying our claims for CPT G0431 urine drug screening Texas Mutual has stated in there original denial and the appeal denial that the ODG documentation requirement for urine drug test have not been met. Texas Mutual is also denying CPT 99214 stating the documentation does not support the level of services billed. However we have review all of the progress notes and high lighted everything required by 1997 AMA Evaluation and Management Guidelines."

Amount in Dispute: \$3,900.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual will pay codes G0431 for dates 12/11/14, 3/31/15 and 6/25/15. The request billed code 99214 for date 1/15/15. Review of the documentation shows it does not meet the CPT criteria for that code. No payment is due. The requestor billed code 96103 for date 6/25/15. This is a psychological testing and it appeared to be for depression, based on the documentation. Texas Mutual denied payment as depression is not part of the compensable injury."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Rows include dates from December 11, 2014 to June 25, 2015 and corresponding CPT codes (G0431, 99214, 96103) and amounts (\$3,900.00, \$378.20).

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 §133.210 sets out the requirements for medical documentation.
3. 28 Texas Administrative Code §133.305 sets out general provisions related to medical dispute resolution.
4. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 16 – Claim/service lacks information or has submission/billing error(s)
  - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of the clarifying information
  - 758 – ODG documentation requirements for urine drug testing have not been met
  - 876 – Required documentation missing or illegible
  - 18 – Exact duplicate claim/service
  - 193 – Original payment decision is being maintained
  - 150 – Payer deems the information submitted does not support this level of service
  - 219 – Based on extent of injury
  - 246 – The treatment/service has been determined to be unrelated to the extent of injury. Final adjudication has not taken place
  - 920 – Reimbursement is being allowed based upon a dispute
  - P12 – Workers’ Compensation jurisdictional fee schedule adjustment

## **Issues**

1. Is extent of injury applicable?
2. Is the carrier’s denial supported?
3. Did the requestor meet division documentation requirements?
4. Did the carrier appropriately request additional documentation?
5. What is the applicable rule pertaining to reimbursement?
6. Is the requestor entitled to additional reimbursement?

## **Findings**

1. The insurance carrier denied the submitted code 96103 for Date of Service June 25, 2015, as 219 – “Based on extent of injury” and 246 – “The treatment/service has been determined to be unrelated to the extent of injury. Final adjudication has not taken place” during the medical bill review process. The date of service referenced above contains an unresolved issue of extent-of-injury (for the same service) for which there is a medical fee dispute. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response during the medical bill review process.

Dispute resolution sequence: 28 Texas Administrative Code §133.305(b) requires that extent-of-injury disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(c) (2) (K) provides that a request for a medical fee dispute must contain a copy of each EOB related to the dispute.

Extent-of-injury dispute process: The Division hereby notifies the requestor that the appropriate process to resolve the issue(s) of extent of injury, including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1. As a result, code 96103 for date of service June 25, 2015 was not considered in this review.

2. The carrier denied code 99214 for date of service January 15, 2015 as 876 – “Required documentation missing or illegible.” 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;

Review of the service in dispute finds;

Submitted code 99214 - 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."

Requirements of the code are as follows:

**History** – Review of systems: Documentation must support review of 2 – 9 systems. Review of the "progress note" for date of service, January 15, 2015 found (10) systems listed. This requirement was met.

**Examination** – Documentation must support review of Up to 7 systems. Review of the "progress note" for date of service, January 15, 2015 found (1) body area and (8) organ systems. This requirement was met.

Per 134.203(b) the submitted medical record does support the services as billed. The carrier's denial is not supported. The service in dispute will be reviewed per applicable rules and fee guidelines.

3. The respondent's claim adjustment code 758 states that "ODG documentation requirements for urine drug testing have not been met." Documentation requirements for the services provided are not established by ODG, rather, documentation requirements are established by 28 TAC §133.210 which describes the documentation required to be submitted with a medical bill. 28 TAC §133.210 does not require documentation to be submitted with the medical bill for the services in dispute. The carrier's denial reason is not supported.
4. The carrier denied payment, in part, with claim adjustment code 225 citing that the documentation does not support the service billed, and that the carrier would "...re-evaluate this upon receipt of clarifying information." Similarly, in its response to this medical fee dispute, the carrier cites the lack of clarifying information and/or documentation as a reason for denial of payment. The process for a carrier's request of documentation not otherwise required by 28 TAC 133.210 is detailed in section (d) of that section as follows:

"Any request by the insurance carrier for additional documentation to process a medical bill shall:

- (1) be in writing;
- (2) be specific to the bill or the bill's related episode of care;
- (3) describe with specificity the clinical and other information to be included in the response;
- (4) be relevant and necessary for the resolution of the bill;
- (5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;
- (6) indicate the specific reason for which the insurance carrier is requesting the information; and
- (7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation."

No documentation was found to support that the carrier made an appropriate request for additional documentation during the billing process with the specificity required by rule. The division concludes that carrier failed to meet the requirements of 28 TAC 133.210(d).

5. 28 Texas Administrative Code 134.203 (c) states,

To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

The maximum allowable reimbursement for 99214 is calculated as follows;

(DWC Conversion Factor / Medicare Conversion Factor) x Fee schedule amount or (56.2 / 35.9335) x \$108.95 = \$170.40. This amount is recommended.

28 Texas Administrative Code 134.203 (e) states in pertinent part,

The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows:

(1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service;

The maximum allowable for clinical laboratory services is calculated as follows:

Date of Service	Submitted Code	MAR	Amount paid	Amount due
December 11, 2014	G0431	\$75.63 x 125% = \$94.54	\$75.82	\$18.72
March 31, 2015	G0431	\$75.63 x 125% = \$94.54	0.00	\$94.54
June 25, 2015	G0431	\$75.63 x 125% = \$94.54	0.00	\$94.54
	Total	\$283.62	\$75.82	\$207.80

6. The maximum allowable reimbursement for all of the services in dispute is \$454.02 (\$283.62 + \$170.40). The carrier paid \$75.82. The remaining balance is \$378.20. This amount is due to the requestor.

**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 \$378.20.

***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 \$378.20 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

December , 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, 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.**