



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

Azalea Orthopedic Sports Medicine

Respondent Name

Texas Mutual Insurance

MFDR Tracking Number

M4-16-1245-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

January 11, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is the provider's position that the carrier denied this procedure in error, and should be required to render payment."

Amount in Dispute: \$200.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The AMA's CPT criteria for 99214 requires the History to be Detailed, the Exam to be Detailed, and the complexity of medical decision making is to be Moderate. With an expanded problem focused History and an expanded problem focused Exam, the documentation does not meet the requisite CPT criteria. No payment is due."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: September 16, 2015, 99214, \$200.00, \$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

- 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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
• 225 – The submitted documentation does not support the service being billed.
• 150 – Payer deems the information submitted does not support this level of service.

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 891 – No additional payment after reconsideration.

Issues

1. Are the insurance carrier’s reasons for denial or reduction of payment supported?
2. What is the rule applicable to reimbursement?
3. 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 service in dispute is 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.”

Review of the submitted documentation finds:

History level based on '95 Guidelines: Expanded Problem Focused
 Exam Level (95): Expanded Problem Focused
 Level of Decision Making: Straightforward

Based on the above, the carrier’s denial reason is supported.

2. Pursuant to Rule 134.203(b) no additional payment can be 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

 Signature

 Medical Fee Dispute Resolution Officer

 January 28, 2016
 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.