



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

DEEPAK V. CHAVDA, MD, PA

Respondent Name

NATIONAL FIRE INSURANCE CO OF HARTFORD

MFDR Tracking Number

M4-16-1701-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

FEBRUARY 19, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The patient diagnosis determines the time and what is done during the E&M. The medical note supports the level of service that was billed."

Amount in Dispute: \$391.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "it was noted the key components of CPT code 99214 requirements were not met as per the AMA's CPT guidelines."

Response Submitted By: Law Office of Brian J. Judis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 6, 2015	CPT Code 99214 Office Visit	\$391.80	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - V122-The level of E&M code submitted is not supported by documentation.

- 150-Payer deems the information submitted does not support this level of service.
- P300-The amount paid reflects a fee schedule reduction.
- P12-Workers' compensation jurisdictional fee schedule adjustment.
- After review of the bill and the medical record, this service is best described by 99213. Submitted documentation did not meet 2 of the 3 key components required for 99214. Lacking a detailed history and a medical decision making of moderate complexity.
- B7-The provider was not certified/eligible to be paid for this procedure/service on this date of service.
- W3-Request for reconsideration.
- 193-Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly.

Issues

Does the documentation support billing code 99214? Is the requestor entitled to reimbursement?

Findings

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 99214 is defined as "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."

A review of the submitted medical report does not support the documentation requirement which require at least 2 of the 3 key components be documented for code 99214; therefore, the Division finds the respondent's denial of reimbursement is supported. As a result, no reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that 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	03/23/2016 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, effective May 31, 2012, *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 MDR 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.