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
Texas Pain Relief Group

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-16-1846-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 3, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Texas Mutual is denying these claims due to ODG guidelines. However ODG Guidelines states we can do 3 drug screens every 6 months and more if the risk level is higher. ...Enclosed you will find the medical records showing that we met 2 of the requirements. We are not required to meet all three per CMS guidelines."

Amount in Dispute: $1,600.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Code 99214 requires two of the three following criteria: a Detailed History, a Detailed History, a Detailed Exam and Moderate complexity of medical decision making. The History is Expanded problem-focused. The Exam is detailed. The decision making is Straightforward. No payment is due. Texas Mutual has elected to pay the G0431 code."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 19, 2015	99214, G0431	$1,600.00	$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.
   - 758 – ODG documentation requirements for urine drug testing have not been met.
   - 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 service Code 99214 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 and the E/M Interactive Score Sheet found at http://www.novitas-solutions.com/webcenter/portal/MedicareJH/EMScoreSheet, finds:

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

   No documentation of time was found within submitted documentation. Based on the above, only one of the required elements of Code 99214 was met, (Level of Decision Making). Therefore, the carrier's denial reason is supported.

   The carrier did not maintain the denial of Code G0431 as they stated, "Texas Mutual has elected to pay the G0431 code" in their response to Medical Fee Dispute.

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	Peggy Miller Medical Fee Dispute Resolution Officer	March 25, 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.