



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

Ahmed Khalifa MD

Respondent Name

LM Insurance Corp

MFDR Tracking Number

M4-16-1977-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

March 14, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134."

Amount in Dispute: \$285.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This procedure was denied per Medicare guidelines and correct coding rules, as documentation does not support this level of service."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 20, 2015	99204, A4556	\$285.90	\$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 claims.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - X901 – Documentation does not support level of service billed.
 - 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
 - U630 – Procedure code not separately payable under Medicare and-or fee schedule guidelines.

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 X901 – "Documentation does not support level of service billed." 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 99204 which is defined as, "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive 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, 45 minutes are spent face-to-face with the patient and/or family."

Pursuant to the Medicare Part B Carrier, Novitas, Evaluation and Management Score Sheet at: http://www.novitas-solutions.com/webcenter/portal/EvaluationandManagement_JH?_afLoop=72449505234000#!%40%40%3F_afLoop%3D7244950523400%26_adf.ctrl-state%3D8q7uaeae0_17,

The following results were found:

- History level: Detailed
- Exam level: Expanded Problem Focused
- Level of Decision Making: Straightforward
- No documentation of time spent face-to-face was found

The carrier's denial is supported as insufficient evidence was found to support the level of service submitted on the March 20, 2015 medical claim in dispute.

Review of Code A4556 finds a status of "P" – Bundled/Excluded code. The carrier denied this service as U630 – "Procedure code not separately payable under Medicare and-or fee schedule guidelines." The carrier's denial is supported.

2. Pursuant to requirements of 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 additional reimbursement for the services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

March , 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.