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
CHANG LEE, DC

Respondent Name
ALLMERICA FINANCIAL BENEFIT INSURANCE COMPANY

MFDR Tracking Number
M4-18-5194-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
AUGUST 24, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary.

Amount in Dispute: $215.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the requestor's submitted documentation the initial medical bill was submitted on 10/24/17 for date of service 08/30/17 in the amount of $293.00. A bill review was conducted under bill id#4354806 and final action rendered on 11/16/17…On 04/03/18 the health care provider submitted a medical bill for date of service 08/30/17 and 02/21/18 in the amount of $430.00. Per division rule §133.250(d)(1) a written request for reconsideration shall reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill. As such, a bill review was conducted, and final action was rendered on 04/26/18 based on duplicate billing as the health care provider failed to meet reconsideration requirements outlined in division rules. A subsequent medical bill was submitted on 07/25/18 for date of service 08/30/17 in the amount of $215.00. A bill review was conducted under bill id#4935023 and final action was rendered on 08/02/18…CorVel hereby certifies a properly completed request for reconsideration was not received for date of service 08/30/17 prior to receipt of this request for medical fee dispute resolution. As such, CorVel respectfully requests the division issue a decision dismissing the request for MFDR in accordance with §133.307(f)(3)(A)."

Position Summary Submitted By: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 30, 2017	CPT Code 99204 Office Visit	$215.00	$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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §133.20 sets out the health care providers billing procedures.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
4. 28 Texas Administrative Code §134.240, effective July 7, 2016, sets the reimbursement guidelines for Designated Doctor Examinations.
5. 28 Texas Administrative Code §133.250 sets out the medical bill processing and audit by insurance carriers procedures.
6. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
7. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
8. The services in dispute were reduced / denied by the respondent with the following reason codes:
    - 105-Additional information needed to review charges.
    - 16-Svc lacks info needed or has billing error(s).
    - R1-Duplicate Billing.
    - 18-Duplicate claim/service.
    - 29-Time limit for filing claim/bill has expired.
    - RM2-Time limit for filing claim has expired.

Issues

Is the respondent's denial of reimbursement for CPT code 99204 rendered on August 30, 2017 supported by the submitted documentation?

Findings

The requestor is seeking reimbursement of $215.00 for office visit, CPT code 99204, rendered on August 30, 2017. The respondent denied reimbursement for CPT code 99204 based upon reason code "105-Additional information needed to review charges," "16-Svc lacks info needed or has billing error(s)," and "29-Time limit for filing claim/bill has expired."

Denial reason "29"

Whether the requestor's medical fee dispute is eligible for review relies upon whether the requestor satisfied the relevant prerequisite requirements as follows:

- 28 Texas Administrative Code §133.20(f) states" Health care providers shall not resubmit medical bills to insurance carriers after the insurance carrier has taken final action on a complete medical bill and provided an explanation of benefits except in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills)."
- 28 Texas Administrative Code §133.20(g) states "Health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier."
- 28 Texas Administrative Code §133.240(a) states "An insurance carrier shall take final action after conducting bill review on a complete medical bill or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended because of a pending request for additional documentation."
- 28 Texas Administrative Code §133.250(d) states "A written request for reconsideration shall: (1) reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill."
- 28 Texas Administrative Code §133.307(c)(2)(J) requires the requestor to submit "a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions)."
- 28 Texas Administrative Code §133.250(i) states "If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills)."

The November 16, 2017 explanation of benefits indicates the requestor billed the respondent on October 24,

2017. This date is within the 95-day timeframe; therefore, the respondent's denial based upon reason code "29" is not supported.

Denial reason "16" and "105"

- 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 99204 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."

A review of the submitted" S.O.A.P. NOTES" dated August 30, 2017 finds the documentation does not meet the 3 key components required for CPT code 99204, specifically a comprehensive history.

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	9/21/2018 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, 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.