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
MANUEL RAMIREZ, MD

Respondent Name
SOUTHERN INSURANCE CO

MFDR Tracking Number
M4-19-1158-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
OCTOBER 31, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We included a copy of the documentation for this code with our original claim and also sent another copy of the documentation with our request for reconsideration."

Amount in Dispute: $178.13

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor billed for a higher office visit than performed. Therefore, no reimbursement is owed for the CPT code 99214 because the requirements were not met."

Response Submitted by: Downs Stanford, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 10, 2018	CPT Code 99214 Office Visit	$178.13	$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 fee guidelines for health care providers billing and reimbursement procedures.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - 227-The report was not included with the billing. This charge will be evaluated upon receipt of the report.
   - 350-Bill has been identified as a request for reconsideration or appeal

- W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. What is the applicable fee guideline?
2. Does the documentation support billing CPT code 99214? Is the requestor due reimbursement?

Findings

1. The fee guidelines for disputed services are found in 28 Texas Administrative Code §134.203.
2. The insurance carrier denied reimbursement for the office visit , CPT code 99214, based upon reason code "16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication," The respondent states, "Requestor billed for a higher office visit than performed."

   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."

   On the disputed dates of service the requestor billed CPT code 99214 described 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."

   The division finds the documentation does not support billing 99214, specifically a detailed examination and medical decision of moderate complexity; therefore, the respondent's denial of payment is supported.

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

		11/29/2018
Signature	Medical Fee Dispute Resolution Officer	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.