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
Texas Mutual Insurance Co

MFDR Tracking Number
M4-19-1746-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
November 26, 2018

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. The carrier has not responded or denied this claim in its entirety following our filing of Request for Reconsideration."

Amount in Dispute: $194.67

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual reviewed the documentation submitted for 99214 and found both the History and Physical Exam were expended problem focused which does not meet the CPT criteria for this code. Texas Mutual has elected to pay code 99080."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 31, 2018	99214 -V5, 99080 -73	$194.67	$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 §133.210 sets out medical documentation requirements.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 150 – Payment adjusted because the payer deems the information submitted does not support this level of service
   - 890 – Denied per AMA CPT Code description for level of service/and or nature of presenting problems

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. The requestor is seeking reimbursement for professional medical services rendered on July 31, 2018 in the amount of $194.67. The disputed Code is 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" and 99080 – Special reports. Per the explanation of benefits submitted with the insurance carrier made a payment of $15.00 on December 13, 2018. This service will not be considered in this review.

   The carrier denied the disputed office visit as, 150 – "Payment adjusted because the payer deems the information submitted does not support this level of service" and "890 – Denied per AMA CPT Code description for level of service/and or nature of presenting problems."

   28 Texas Administrative Code §133.210 (c)(1) states in pertinent part,

   > In addition to the documentation requirements of subsection (b) of this section, medical bills for the following services shall include the following supporting documentation:
   >
   > > (1) the two highest Evaluation and Management office visit codes for new and established patients: office visit notes/report satisfying the American Medical Association requirements for use of those CPT codes;

   Review of the submitted documentation titled "Occupational Medicine Clinic Follow Up" July 31, 2018 finds;

   - History level based on '95 Guidelines: Expanded Problem Focused
   - Exam Level (95): Expanded Problem Focused
   - Level of Decision Making: Straightforward
   - No documentation of time available in submitted documents

   Based on the above, the Division finds the carrier's denial is supported as the documentation requirements of the submitted code (99214) was not met.

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

		January 25, 2019
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.