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
UT PHYSICIANS

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-19-3421-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 12, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position statement for review.

Amount in Dispute: $230.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual Insurance maintains its position as explained by its EOBS."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
September 11, 2018	Professional Medical Services	$230.00	$179.65

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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 guideline for professional medical services.
3. Insurance Code §1305.006 establishes insurance carrier liability for certain out-of-network care.
4. Insurance Code §1305.153 requires non-network providers be reimbursed according to the Texas Labor Code.
5. This dispute regards out-of-network care approved by the network in accordance with Insurance Code §1305.006. Consequently, this request for reimbursement is reviewed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE.
   - 725 – APPROVED NON-NETWORK PROVIDER FOR TEXAS STAR NETWORK CLAIMANT PER RULE 1305.153(C).
   - 876 – REQUIRED DOCUMENTATION MISSING OR ILLEGIBLE. SEE RULES 133.1; 133.210; 129.5; OR 180.22
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
- 350 – BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824
- 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 of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes:
   - 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
   - 890 – DENIED PER AMA CPT CODE DESCRIPTION FOR LEVEL OF SERVICE AND/OR NATURE OF PRESENTING PROBLEMS.

   This dispute regards a medical evaluation with reimbursement subject to the division's *Medical Fee Guideline for Professional Services*, Rule §134.203(b)(1), requiring that for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply "Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers . . . and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The provider billed the evaluation using CPT code 99214, which is defined as an office or outpatient visit for the evaluation and management of an established patient, requiring at least 2 of 3 key components: a detailed history; a detailed examination; and medical decision making of moderate complexity.

   Review of the submitted information in accordance with Medicare evaluation guidelines finds:

   - Detailed history: requiring documentation at a detailed level of 3 of the following 4 history areas – status of chronic conditions (12 conditions were documented in the record); history of present illness (the record documents at least 5 elements, including location, duration, severity, modifying factors and associated signs and symptoms); review of symptoms (the review of symptoms was not extended, only pertinent to the problem at best); however, pertinent past medical/family/social history was documented sufficiently to meet the criteria as the third area necessary for a detailed history.
   - Examination: a detailed examination requires in depth, extended exam of 7 or more body areas or organ systems. This component could not be found documented in the submitted medical record.
   - Medical decision making: the doctor diagnosed a severe chronic condition and an acute complicated injury. No diagnostic procedures were ordered or reviewed. No referrals or consults were documented. However, the record does support drug management of 4 prescription drugs and one over-the-counter drug, sufficient to support medical decision making of moderate complexity.
   - Face-to-face time spent with the injured employee was not documented in the record.

   Based on the findings above, the medical record supports 2 of the necessary key components (detailed history and moderately complex medical decision making) sufficient to meet the definition of the service. The division thus concludes the submitted documentation supports code 99214 as billed.

   The insurance carrier's denial reasons are not supported. The disputed services will therefore be reviewed for payment in accordance with division rules and fee guidelines.

2. Rule§134.203(c) requires the maximum allowable reimbursement (MAR) be determined by applying Medicare payment policy modified by DWC rules. The MAR is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the DWC conversion factor.

   Reimbursement is calculated as follows:

   - Procedure code 99214, September 11, 2018, has a Work RVU of 1.5 multiplied by the Work GPCI of 1.02 is 1.53. The practice expense RVU of 1.44 multiplied by the PE GPCI of 1.012 is 1.45728. The malpractice RVU of 0.1 multiplied by the malpractice GPCI of 0.936 is 0.0936. The sum is 3.08088 multiplied by the DWC conversion factor of $58.31 for a MAR of $179.65.

   The total allowable reimbursement for the disputed services is $179.65. The insurance carrier paid $0.00. The amount due is $179.65. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division emphasizes the findings in this decision are based on the available evidence presented by the requestor and respondent up to the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $179.65.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $179.65, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	April 5, 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 Rule §133.307.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.