



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

OrthoTexas Physicians

Respondent Name

Technology Insurance Co

MFDR Tracking Number

M4-20-2250-01

Carrier's Austin Representative

Box Number 17

MFDR Date Received

May 13, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "See the attached dictation that supports the services rendered."

Amount in Dispute: \$600.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...Requestor billed for a higher office visit than performed."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 1, 2019 and December 10, 2019	Physician Office Visit	\$600.00	\$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 reimbursement guidelines for professional medical services.
- 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)
 - 205 – This charge was disallowed as additional information/definition is required to clarify service/supply rendered

Issues

1. Is the insurance carrier’s denial of payment supported?

Findings

1. The requestor is seeking reimbursement for office visits done in October and December of 2019. The insurance carrier denied based on submitted information.

28 TAC §134.203 (b) states in pertinent part 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; and modifiers. The submitted code in dispute is 99214 with a definition of, “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.

Review of the submitted documentation per the Medicare E/M 1995 guidelines found:

- History – Expanded Problem Focused
- Exam Level - Problem focused
- Level of Decision Making – Moderate Complexity
- Total documented time – 25 minutes

Based on the above only one of the required three components was met. The insurance carrier’s denial is supported.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has not established payment is due. As a result, the amount ordered is \$0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

June 6, 2020

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, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.