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
ELITE HEALTHCARE FORT WORTH

Respondent Name
ACE AMERICAN INSURANCE CO

MFDR Tracking Number
M4-21-1549-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
MAY 4, 2021

REQUESTOR'S POSITION SUMMARY

"These bills were previously submitted in a timely manner. Please review the attached documentation any pay according to the TDI guidelines."

Amount in Dispute: $275.08

RESPONDENT'S POSITION SUMMARY

"We will provide a supplemental response once the bill auditing company has finalized their review."

Response Submitted By: Gallagher Bassett Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 1, 2020	CPT Code 99204 Office Visit	$275.08	$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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective February 22, 2021, sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 150, 00168-Payer deems the information submitted does not support this level of service.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 5352-CV: Service reduced/denied as level of E&M code is not supported by documentation.
   - B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.
   - 247-A payment or denial has already been recommended for this service.
   - 5283-Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, provider's contract, or car

Issues

Does the documentation support billing CPT code 99204? Is the requestor due reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $275.08 for CPT code 99204 rendered on June 1, 2020.
2. The respondent denied reimbursement for CPT code 99204 based upon the documentation did not support the level of service billed.
3. The fee guidelines for disputed services are found in 28 TAC §134.203.
4. 28 TAC §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 described 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."

   The division finds the submitted report does not sufficiently support a comprehensive history, specifically a detailed family history, that is required for billing code 99204; therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the DWC 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 DWC has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		06/30/2021
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, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **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.