



Medical Fee Dispute Resolution Findings and Decision General Information

Requester Name

LEWIS RICHARD NEEL, MD

Respondent Name

NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number

M4-23-0022-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

September 1, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 25, 2022	99214-25	\$198.00	\$0.00
Total		\$198.00	\$0.00

Requester's Position

The requestor did not submit a position summary for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Amount in Dispute: \$198.00

Respondent's Position

"Per the AMA, effective 1/1/2021, a moderate level of decision making should be documented to support 99214. Corvel deemed that the documentation submitted for 99214-25 did not meet AMA criteria. In order for 99214-25 to be validated for reimbursement, 1) documentation must contain moderate levels of the number and complexity of problems addressed. The DX billed... meets low level; 2) Amount and/or complexity of data to be review and analyzed does not meet moderate level. There was no review of unique testing (testing not charged by physician), ordering of tests or reviewing of prior external note(s); no discussion or mgt or test interpretation with external physician/other qualified HCP; 3) Risk of complications and/or morbidity or mortality of patient management – Prescription management documented and use of ice on knee. All 3 factors considered, HCP did not meet a moderate level of Medical Decision Making, thus payment denial was maintained."

Response Submitted by: CORVEL

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Insurance Code Chapter 1305 applies to health care certified networks.

Denial Reason(s)

The insurance carrier reduced or denied payment for the services in dispute with the following claim adjustment code(s):

- 150 – Payment adjusted/unsupported service level.
- W3 – Appeal/reconsideration.
- O4P – Services unsubstantiated by documentation.

Issues

1. Is this dispute eligible for medical fee dispute resolution under 28 TAC §133.307?
2. Is the requestor entitled to reimbursement for CPT Code 99214-25?

Findings

1. The requestor filed this medical fee dispute to the DWC asking for resolution pursuant to 28 TAC §133.307 titled *MDR of Fee Disputes*. The authority of the Division of Workers' Compensation to resolve matters involving employees enrolled in a certified health care network is limited to the conditions outlined in the applicable portions of the Texas Insurance Code (TIC), Chapter 1305 and limited application of Texas Labor Code statutes and rules, including 28 TAC §133.307.

Texas Insurance Code §1305.106 provides that "An insurance carrier that establishes or contracts with a network is liable for the following **out-of-network** health care that is provided to an injured employee... (3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section [1305.103](#)."

TIC §1305.153 (c) provides that "Out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation."

The respondent states in pertinent part, "...HCP mentions network; however, the network issue was addressed. The appeal was denied for level of service not being supported in the documentation."

The DWC finds that the requestor obtained an out-of-network referral. As a result, the disputed services are eligible for review by medical fee dispute resolution.

2. The requestor seeks reimbursement for CPT Code 99214-25 rendered on January 25, 2022. The insurance carrier denied the disputed service with denial reduction codes, 150, and O4P description provided above.

The fee guidelines for disputed services are found in 28 TAC §134.203.

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 99214 is 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 submitted report does not sufficiently support a medical decision of moderate complexity as required when billing CPT Code 99214; therefore, reimbursement is not recommended.

The DWC finds that the requestor is not entitled to reimbursement for CPT Code 99214-25 rendered on January 24, 2022.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

The DWC finds the requester has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to reimbursement for the disputed services.

Authorized Signature



Signature

Medical Fee Dispute Resolution Officer

September 27, 2022

Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252- 7031, Option 3, or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

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