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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Killeen Injury Clinic

Respondent Name
Employers Preferred Ins. Co

MFDR Tracking Number
M4-14-0720-01

Carrier's Austin Representative
Box Number 04

MFDR Date Received
October 30, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is our position that the insurance company is delaying payment of the claims that were preauthorized and rendered to (claimant)."

Supplemental response from January 23, 2014: MDR Tracking #: M4-14-0720-01: The attached file with "X" next to the date of service are not yet paid.

Amount in Dispute: $7,049.00 (From above the correspondence total of dispute for charges marked with "X" is $2,615.00)

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have received the attached MFDR and have reviewed all charges. The charges for 12/06/12 in the amount of $260.00 have been denied based on "the information submitted does not support this level of service." It was denied on 1/29/13 and again on 03/11/13. Provider will need to provide the appropriate information for bill to be processed for payment. Coventry, our billing audit company, denied both times for this reason. The charges for the period of 04/03/13-07/31/13 were reviewed by adjuster. Carrier will send these to Coventry to be process for payment per state fee guidelines and ODG... "

Response Submitted by: Employers Insurance Company of Nevada, 2550 Paseo Verde Parkway, Suite 100, Henderson, NV 89074-7117

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 6, 2012	99214 (DWC 60 shows 99204) Claim for 99214	$260.00	
May 8, 2013	90901	$780.00	
May 22, 2013	90834-59	$145.00	
May 22, 2013	90889	$90.00	
May 30, 2013	90834-59	$145.00	$1,868.10
May 30, 2013	90889	$90.00	
May 30, 2013	90901	$780.00	
June 6, 2013	97110	$150.00	
June 13, 2013	99214	$175.00	

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.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.230 sets out reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of healthcare.
4. 28 Texas Administrative Code §134.120 sets out reimbursement guidelines for medical documentation.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 150 – Payer deems the information submitted does not support this level of service
   - 50 – These are non-covered service because this is not deemed a medical necessity

Issues

1. Was the disputed service supported by documentation?
2. Did the requestor receive prior authorization for services still in dispute?
3. What is the applicable rule pertaining to reimbursement?
4. Is the separate billing of reports payable?
5. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the claim for date of service December 6, 2012 as 150 – "Payer deems the information submitted does not support this level of service." 28 Texas Administrative Code § 134.203(b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;…" Review of the submitted medical bill finds the health care provider submitted 99204 – "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 supporting documentation "Initial Rehab Evaluation" dates 12/6/2012 was reviewed per CMS Evaluation and Services Guide, http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf , and shows the following;
   a. History / Score - Comprehensive
      i. Status of chronic conditions; Three chronic conditions documented
      ii. History of Present Illness elements; Five elements documented
      iii. Review of systems ; Six elements documented
      iv. Past medical, family, social history; Three areas documented
   b. Examination / Score - Expanded problem focused
      i. Body areas; Three body areas documented
      ii. Organ systems; Six organ systems documented
   c. Medical decision making / Score – Low Complexity

   The Division finds the submitted documentation does not support the required 3 components were met. The Carrier's denial is supported. No additional payment is recommended.

   For date of service, June 13, 2013, review of the submitted medical documentation finds;
   a. History / Score – Expanded Problem Focused
      i. Status of chronic conditions; Two chronic conditions documented
      ii. History of Present Illness elements; Three elements documented
      iii. Review of systems ; One element documented
      iv. Past medical, family, social history; None
   b. Examination / Score - Expanded problem focused

v. Body areas; Two body areas documented
vi. Organ systems; Two organ systems documented

c. Medical decision making / Score – Low Complexity

The Division finds the submitted documentation does not support the required 3 components to support level of service billed were met. No additional payment can be recommended.

2. The carrier denied disputed services as, 50 – "These are non-covered service because this is not deemed a medical necessity." 28 Texas Administrative Code §134.600 (l) states in pertinent part, "The insurance carrier shall not withdraw a preauthorization or concurrent utilization review approval once issued." Review of the submitted documentation find utilization review was done prior to services provided and treatment was supported by the available documentation and by ODG recommendations. Authorization was recommended. Specifically;
   a. UniMed Direct ID: 1338518 – "Negotiated approval for 5 visits of up to 4 units total comprised of codes 97110, 97530, and 97140. Approval start and end dates (05/20/2013 – 06/07/2013)."
   b. UniMed Direct ID: 1326307 – "Request: Individual Psychotherapy 1x4 weeks and Biofeedback Therapy 1x4 weeks, CPT 90834, 90901. Recommendation: Approval Start and End Dates 4/30/2013 – 6/07/2013."

   The claims that were authorized per the above are;
   - 05/08/13 – 90901
   - 05/22/13 – 90834
   - 05/30/13 – 90834
   - 05/30/13 – 90901
   - 06/06/13 – 97110

   These claims will be reviewed per applicable rules and fee guidelines.
3. 28 Texas Administrative Code §134.230 (c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor). The maximum allowable reimbursement will be calculated as follows;

Date of Service	Submitted Code	Billed Amount	Units	Maximum Allowable Reimbursement (TDI-DWC Conversion Factor / Medicare Conversion Factor) x Non-Facility Price = MAR
May 8, 2013	90901	780.00	12	(55.3 / 34.023) x 37.50 x 12 = $731.42
May 22, 2013	90834 - 59	145.00	1	(55.3 / 34.023) x 78.95 = $128.32
May 30, 2013	90834 - 59	145.00	1	(55.3 / 34.023) x 78.95 = $128.32
May 30, 2013	90901	780.00	12	(55.3 / 34.023) x 37.50 x 12 = $731.42
June 6, 2013	97110	150.00	3	(55.3 / 34.023) x 30.48 x 3 = $148.62
			Total	$1,868.10

   The total MAR is $1,868.10. This amount is recommended.
4. 28 Texas Administrative Code §134.120 (f) states, "The reimbursements for medical documentation are:" and (g) states, "Narrative reports are defined as original documents explaining the assessment, diagnosis, and plan of treatment for an injured employee written or orally transcribed and created at the written request of the insurance carrier or the Division. Narrative reports shall provide information beyond that required by prescribed medical reports and/or records. A narrative report should be single spaced on letter-size paper or equivalent electronic document format. Clinical or progress notes do not constitute a narrative report.

   Review of the disputed charges finds the requestor submitted claims for 90889 – "Preparation of report of patient's psychiatric status, history, treatment, or progress…" Based on Rule 134.120 (f) (g). The submitted claim does not meet the definition of a narrative report and is not separately payable.
5. The total recommended payment for the services in dispute is $1,868.10. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $1,868.10. This amount is recommended.

Conclusion

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 $ 1,868.10.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,868.10 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		March 12, 2015
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 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 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 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.