



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

Elite Healthcare North Dallas

Respondent Name

Old Republic Insurance Co

MFDR Tracking Number

M4-14-0736-01

Carrier's Austin Representative

Box Number 44

MFDR Date Received

November 1, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached dates of services 5/23/13, 7/2/13, 7/10/13, 7/29/13 were not paid in full. We have met all key components. Not to mention, the work status reports were paid for both of these dates of services..."

Amount in Dispute: \$1,100.42

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute resolution received. However, no position statement was submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 23, 2013	99204	\$1,100.42	\$238.44
July 2, 2013	99214		
July 10, 2013	99213, 97140, 97112, 97110		
July 29, 2013	99213		

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 15 – Payer deems the information submitted does not support this level of service.
 - 16 – Claim/service lacks information which is needed for adjudication
 - 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing

Issues

1. Did the requestor support the level of services submitted?
2. Was necessary information included with the claim?
3. Was an appropriate modifier used in combination with disputed service?

Findings

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on November 11, 2013. The insurance carrier did not submit a response for consideration in this review. Per the Division's former rule at 28 Texas Administrative Code §133.307(d)(1), effective May 25, 2008, 33 *Texas Register* 3954, "If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information." Accordingly, this decision is based on the available information.
2. The carrier denied the May 23, 2013 date of service for CPT code 99204 as, 15 – "Payer deems the information submitted does not support this level of service." 28 Texas Administrative Code §134.203(b)(1) 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; ... and other payment policies in effect on the date a service is provided..." Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient. The American Medical Association (AMA) CPT code description for 99204 is:

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 1997 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare policy. It describes the documentation requirements for the service in dispute. Review of the documentation finds the following:

- Documentation of the Comprehensive History
 - History of Present Illness (HPI) consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions. Documentation found listed two chronic conditions, thus not meeting this component.
 - Review of Systems (ROS) inquires about the system (s) directly related to the problem(s) plus additional body systems. At least ten organ systems must be reviewed. Documentation found listed one system, this component was not met.
 - Past Family, and/or Social History (PFSH) requires a review of two or all history areas, at least one specific item from each history areas to be documented. The documentation found listed no areas. This component was not met.
 - Documentation of a Comprehensive Examination: Requires at least nine organ systems to be documented, with at least two elements listed per system. The documentation found listed one body areas and two systems: This component was not met.

The division concludes that the documentation does not sufficiently support the level of service billed. The Carrier's denial is supported. No payment can be recommended.

The carrier denied the July 2, 2013 date of service for CPT code 99214 as, 15 – "Payer deems the information submitted does not support this level of service." 28 Texas Administrative Code §134.203(b)(1) 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; ... and other payment policies in effect on the date a service is provided..." Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient. The American Medical Association (AMA) CPT code description for 99214 is:

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 1997 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare policy. It describes the documentation requirements for the service in dispute. Review of the documentation finds the following:

- Documentation of the Detailed History
 - History of Present Illness (HPI) consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions. Documentation found listed two chronic conditions, thus this component was not met.
 - Review of Systems (ROS) requires two to nine systems to be documented. Documentation found one listed, this component was not met.
 - Past Family, and/or Social History (PFSH) requires at least one specific item from any three history areas to be documented. The documentation found no history areas. This component is not met.
- Documentation of a Detailed Examination:
 - Requires at least six organ systems to be documented, with at least two elements per listed system. The documentation found listed two body areas. This component was not met.

The division concludes that the documentation does not sufficiently support the level of service billed. The Carrier's denial is supported. No payment can be recommended.

The carrier denied July 10, 2013 submitted charge for CPT codes 99213, as, 16 – “This claim/service lacks information which is needed for adjudication.” 28 Texas Administrative Code §134.203(b)(1) 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; ... and other payment policies in effect on the date a service is provided...” Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient. The American Medical Association (AMA) CPT code description for 99213 is: “Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and 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 low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.”

The 1997 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare policy. It describes the documentation requirements for the service in dispute. Review of the documentation finds the following:

- Documentation of the Expanded History
 - History of Present Illness (HPI) consists of one to three elements of the HPI. Documentation found listed one chronic condition, component was met.
 - Review of Systems (ROS) inquires about the system directly related to the problem(s) identified in the HPI. Documentation found relating to “reduced motion” of right shoulder and left knee. This component was met.
 - Past Family, and/or Social History (PFSH) are not applicable.
- Documentation of a Expanded Examination:
 - Requires limited examination of the affected body area. Review of documentation finds record relates to affected body areas of Right shoulder and Left knee and includes: “Activity of living, muscle strength, range of motion”. This component was met.

The division concludes that the documentation does sufficiently support the level of service billed for this code and will be calculated per applicable rules and fee guidelines.

- Procedure code 99213, service date July 10, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.97873. The practice expense (PE) RVU of 1.1 multiplied by the PE GPCI of 1.017 is 1.1187. The

malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.834 is 0.05838. The sum of 2.15581 is multiplied by the Division conversion factor of \$55.30 for a MAR of \$119.22. This amount is recommended.

As stated above, 28 Texas Administrative Code §134.203(b)(1) 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; ... and other payment policies in effect on the date a service is provided.” The codes 97140, 97112 and 97110 are timed codes. Per Medicare Med Learn Matters Article, Fact Sheet, titled, “Outpatient Rehabilitation Therapy Services: Complying with Documentation Requirements”, “Total treatment minutes of the patient, including those minutes of active treatment reported under the timed codes and those minutes represented by the untimed codes, must be documented.” No documentation of beginning and ending times to support number of units billed was found. The carrier’s denial for these services is supported. No payment can be recommended.

3. The carrier denied CPT code 99213, - 25, for date of service July 29, 2013 as, 4 – “The procedure code is inconsistent with the modifier used or a required modifier is missing.” The definition of the 25 modifier is found to be, “Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service. It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient’s condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported.” The carrier’s denial is not supported. The procedure will be reviewed per applicable rules and fee guidelines.
 - Procedure code 99213, service date July 29, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.97873. The practice expense (PE) RVU of 1.1 multiplied by the PE GPCI of 1.017 is 1.1187. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.834 is 0.05838. The sum of 2.15581 is multiplied by the Division conversion factor of \$55.30 for a MAR of \$119.22. 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 \$238.44.

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 \$238.44 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

October 8, 2014
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.