



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 HEATHCARE FORT WORTH

Respondent Name

INDEMNITY INSURANCE CO.

MFDR Tracking Number

M4-14-0967-01

Carrier's Austin Representative

BOX NUMBER: 15

MFDR Date Received

NOVEMBER 25, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Patient had Team Conference on 8.2.2013 and it was paid in full. Patient had exact claim on 5.3.2013, can't pay one and not the other. These are incorrect denials. All other office visits have been paid in full, with that said date of service 5.9.2013 should be paid for in full also."

Amount in Dispute: \$229.39

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The first date of service in dispute is 5/9/2013. Requestor billed for an office visit in conjunction with physical therapy services and used the modifier -25. However, this was an incorrect use of this modifier as there were no other E&M (evaluation & Management) services billed on the same date of service. Additionally, the documentation did not support the level of service. The office notes were illegible and did not contain two of the following: a problem focused history; a problem focused examination; nor straightforward medical decision making. Therefore, Respondent's denial of the service was appropriate. For the date of service 5/3/13, Requestor billed for a team conference. This conference did not meet the requirements of DWC Rule 134.204(e)(1)(B)(2) which states that team conference and telephone calls should be triggered by a documented change in the condition of the injured employee. There is not documented changes in condition of the Claimant. As such, the documentation does not support he services billed."

Response Submitted by: DOWNS STANFORD, PC.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 3, 2013	CPT Code 99361	\$113.00	\$113.00
May 9, 2013	CPT Code 99213-25	\$116.39	\$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.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the reimbursement guidelines for Division specific services.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for E/M services.

The services in dispute were reduced/denied by the respondent with the following reason codes:

- MT04 – Physical Medicine-Chiropractic Services rendered beyond 90 days from DOI.
- MT02 – Physical Medicine=Chiropractic Services rendered beyond \$5,000.00 since DOI.
- P304 – Line paid at 100 percent of the billed charges.
- V178 – CV: The E&M service documented does not meet the CPT requirements for modifier -25. Service should not be billed separately.
- 4 (4) – The procedure code is inconsistent with the modifier used or a required modifier is missing.
- B12 (B12) – Services not documented in patients' medical records.
- V180 – CV: Documentation does not support the type of therapeutic procedure performed, per CPT definition.

Issues

1. Did the requestor meet the requirements for Team Conferences?
2. Did the requestor meet the requirements of 28 Texas Administrative Code §134.203?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.204(e) states, Case Management Responsibilities by the Treating Doctor is as follows: (1) Team conferences and telephone calls shall include coordination with an interdisciplinary team. (A) Team members shall not be employees of the treating doctor. (B) Team conferences and telephone calls must be outside of an interdisciplinary program. Documentation shall include the purpose and outcome of conferences and telephone calls, and the name and specialty of each individual attending the team conference or engaged in a phone call. (2) Team conferences and telephone calls should be triggered by a documented change in the condition of the injured employee and performed for the purpose of coordination of medical treatment and/or return to work for the injured employee. (3) Contact with one or more members of the interdisciplinary team more often than once every 30 days shall be limited to the following: (A) coordinating with the employer, employee, or an assigned medical or vocational case manager to determine return to work options; (B) developing or revising a treatment plan, including any treatment plans required by Division rules; (C) altering or clarifying previous instructions; or (D) coordinating the care of employees with catastrophic or multiple injuries requiring multiple specialties. (4) Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity. Case management services shall be billed and reimbursed as follows: (A) CPT Code 99361. (i) Reimbursement to the treating doctor shall be \$113. Modifier "W1" shall be added. (ii) Reimbursement to the referral HCP shall be \$28 when a HCP contributes to the case management activity. The respondent denied the services using denial codes, B12 – "Services not documented in the patients' medical records" and V180 – "Documentation does not support the type of therapeutic procedure performed, per CPT definition." Review of the respondent's documentation finds that the denial reasons are not supported. Therefore, reimbursement is recommended.
2. 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: 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 one chronic conditions, thus meeting this component.
 - Review of Systems (ROS) requires two to nine systems to be documented. Documentation found listed two systems, this component was 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 areas listed. This component was 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 2 body/organ system: musculoskeletal. This component was not met.
- The respondent denied the office visits using denial codes V178 – CV: “The E&M service documented does not meet the CPT requirements for modifier -25. Service should not be billed separately” and 4 (4) – “The procedure code is inconsistent with the modifier used or a required modifier is missing. Review of the requestors information finds insufficient documentation to support the service rendered. Therefore, reimbursement is not recommended.
- The Requestor also attached modifier -25 to the office visits. This modifier is defined as “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.” Review of the office visits note finds insufficient documentation to support the use of the modifier.

The division concludes that the documentation does not sufficiently support the level of service billed.

3. For the reasons stated above, the Team Conference – CPT Code 99361 is the only disputed issue eligible for payment.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is not due. As a result, the amount ordered is \$113.00.

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 \$113.00 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

June 27, 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.