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 Fort Worth

Respondent Name
Commerce and Industry Insurance

MFDR Tracking Number
M4-14-1368-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 17, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am resubmitting the claim for payment for the following reasons: THIS IS NOT A DUPLICATE CLAIM/SERVICE. These claims were sent in for reconsideration and were still denied as not enough information to support level or service or services not documented in patients' medical records. Treating provider has enclosed dictation that was also sent in with reconsideration. Office visits are recommended as determined to be medically necessary. I'm taking the next step to get the rest of these claims paid and sending all documentation I have to MDR. THESE ARE NOT DUPLICATES. All other claims have been paid at 100%. Therefore, these claims should be paid in full."

Amount in Dispute: $349.17

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Commerce & Industry Insurance has reviewed the Medical Fee Dispute Resolution Request/Response (DWC-60). It is the Carrier's position that there is no additional money owed to the requestor, Elite Healthcare Fort Worth for 9/12/2013, 9/19/2013 and 10/9/2013 dates of services for treatment. The bills have been audited two separate times. The bills were paid in accordance with the Workers Compensation State Fee Guidelines. The Carrier is going to maintain their denial that the additional $349.17 is not owed to the requestor, Elite Healthcare Fort Worth."

Response Submitted by: AIG Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 12 – October 9, 2013	Evaluation & Management, Established Patient (99213)	$349.17	$232.78

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 §134.203 sets out the fee guidelines for billing and reimbursing professional medical bills.

3. 28 Texas Administrative Code §133.210 sets out the procedures for medical documentation regarding medical bills.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   For date of service 9/12/13:
   - 150 – Payer deems the information submitted does not support this level of service.
   - VF01 – Documentation does not support level of service billed.
   - VM02 – Reviewer has previously reconsidered these items timely and properly. No new information has been submitted to justify an additional review.

   For date of service 9/19/13:
   - B12 – Services not documented in patients' medical records.
   - VG06 – Per clinical guidelines, separately identifiable evaluation and management services, above and beyond any pre or post work associated with CMT, is not supported by documentation provided.
   - VM02 – Reviewer has previously reconsidered these items timely and properly. No new information has been submitted to justify an additional review.

   For date of service 10/9/13:
   - B12 – Services not documented in patients' medical records.
   - VF09 – No significant identifiable evaluation and management service has been documented.
   - VG06 – Per clinical guidelines, separately identifiable evaluation and management services, above and beyond any pre or post work associated with CMT, is not supported by documentation provided.
   - VM02 – Reviewer has previously reconsidered these items timely and properly. No new information has been submitted to justify an additional review.

Issues

1. Is the carrier's denial for lack of documentation supported?
2. Were the charges for the disputed services supported?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The workers' compensation carrier (carrier) denied services for dates of service September 19, 2013 and October 9, 2013, in part, due to lack of supporting documentation. Documentation requirements are established by 28 Texas Administrative Code §133.210 which describes the documentation required to be submitted with a medical bill. 28 Texas Administrative Code §133.210 does not require documentation to be submitted with the medical bill for the services in dispute.

   Further, the process for a carrier's request of documentation not otherwise required by 28 Texas Administrative Code §133.210 is described in section (d) of that section as follows:

   "Any request by the insurance carrier for additional documentation to process a medical bill shall:
   (1) be in writing;
   (2) be specific to the bill or the bill's related episode of care;
   (3) describe with specificity the clinical and other information to be included in the response;
   (4) be relevant and necessary for the resolution of the bill;
   (5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;
   (6) indicate the specific reason for which the insurance carrier is requesting the information; and
   (7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation."

   No documentation was found to support that the carrier made an appropriate request for additional documentation with the specificity required by §133.210(d). The Division concludes that carrier failed to meet the requirements of 28 Texas Administrative Code 133.210(d). The carrier's denial for this reason is not appropriate.

1. 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 [emphasis added]. 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 guideline to determine the documentation requirements for the service in dispute. Review of the documentation finds the following:

- Documentation of the Expanded Problem Focused History:
  - "A *brief* [History of Present Illness (HPI)] consists of one to three elements of the HPI [or may include the status of1-2 chronic or inactive conditions]."
  - "A *problem pertinent* [Review of Systems (ROS)] inquires about the system directly related to the problem(s) identified in the HPI."
  - A Past Family, and/or Social History (PFSH) is not required for this component.

  The Guidelines state, "To qualify for a given type of history all three elements in the table must be met."
- Documentation of the Expanded Problem Focused Examination:
  - An "*expanded problem focused examination* [for a single body area or organ system] should include performance and documentation of at least six elements identified by a bullet (·), whether in a shaded or unshaded border."
- Documentation of Decision Making of Low Complexity:
  - *Number of diagnoses or treatment options* – The number of problems, whether the problem is diagnosed, and types of treatment recommended are taken into account.
  - *Amount and/or complexity of data to be reviewed* – This can include diagnostic tests ordered or reviewed and data reviewed from another source.
  - *Risk of complications and/or morbidity or mortality* – "The highest level of risk in any one category (presenting problem(s), diagnostic procedure(s), or management options) determines overall risk."

  "To qualify for a given type of decision making, **two of the three elements … must be either met or exceeded**."

For date of service September 12, 2013: The submitted documentation supports that the requestor provided a review of five (5) elements of HPI, a review of two (2) systems, and no elements of PFSH. This meets the documentation guidelines for an expanded problem focused history. The submitted report shows that the requestor included the performance and documentation of three (3) elements of the Musculoskeletal Examination Table, which does not meet the documentation criteria for an expanded problem focused examination. The submitted documentation supports that the requestor exceeded the requirements for documentation of Decision Making of Low Complexity. **Because the documentation indicates that the requestor met or exceeded two (2) of the required key components of CPT Code 99213, the requestor did support this level of service.**

For date of service September 19, 2013: The submitted documentation supports that the requestor provided a review of four (4) elements of HPI, a review of one (1) system, and one (1) element of PFSH. This meets the documentation guidelines for an expanded problem focused history. The submitted report shows that the requestor included the performance and documentation of three (3) elements of the Musculoskeletal Examination Table, which does not meet the documentation criteria for an expanded problem focused examination. The submitted documentation does not support that the requestor met the requirements for documentation of Decision Making of Low Complexity. **Because the documentation indicates that the requestor did not meet or exceed at least two (2) of the required key components of CPT Code 99213, the requestor did not support this level of service.**

For date of service October 9, 2013: The submitted documentation supports that the requestor provided a review of four (4) elements of HPI, a review of one (1) system, and one (1) element of PFSH. This meets the documentation guidelines for an expanded problem focused history. The submitted report shows that the requestor included the performance and documentation of three (3) elements of the Musculoskeletal Examination Table, which does not meet the documentation criteria for an expanded problem focused examination. The submitted documentation supports that the requestor exceeded the requirements for documentation of Decision Making of Low Complexity. **Because the documentation indicates that the requestor met or exceeded two (2) of the required key components of CPT Code 99213, the requestor did support this level of service.**

2. Procedure code 99213, service date September 12, 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 is 0.97. The practice expense (PE) RVU of 1.1 multiplied by the PE GPCI of 0.979 is 1.0769. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.826 is 0.05782. The sum of 2.10472 is multiplied by the Division conversion factor of $55.30 for a MAR of $116.39.

Because the requestor did not meet the fee guidelines for date of service September 19, 2013, no further reimbursement is recommended for this date of service.

Procedure code 99213, service date October 9, 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 is 0.97. The practice expense (PE) RVU of 1.1 multiplied by the PE GPCI of 0.979 is 1.0769. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.826 is 0.05782. The sum of 2.10472 is multiplied by the Division conversion factor of $55.30 for a MAR of $116.39.

The total allowable for the disputed services is $232.78. Review of the submitted documentation finds that the insurance carrier paid $0.00 for these services. Therefore an additional recommendation of $232.78 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 $232.78.

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 $232.78 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	March 19, 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.