TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Ahmed Khalifa, M.D., P.A.

Respondent Name
American Economy Insurance Company

MFDR Tracking Number
M4-14-1925-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
February 28, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… the medical bill of $232.16 for the procedural code 99215 and $415.88 for the procedural code 27096-50 were denied. The reasons for the denial were 'Payer deems the information submitted does not support this level of service & precertification/authorization absent.'"

Amount in Dispute: $648.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "… CPT 99215 was denied as the documentation submitted by the provider did not support the AMA Guidelines of the CPT code billed … CPT 27086-50 was denied for no authorization.

After a review of the providers appeal letter dated 01/17/2014 is was noted that CPT 27086-50 did not require authorization and was processed for payment at the providers billed charge of $415.88 on 01/31/2014. CPT 99215 remains denied as the provider has not submitted any additional information to support the level of service billed…"

Response Submitted by: Coventry Workers' Comp Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 18 & 23, 2013	Evaluation & Management, established patient (99215) Sacroiliac Joint Injection (27096-50)	$648.04	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 professional medical services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   For CPT Code 99215:
   - 150 – Payer deems the information submitted does not support this level of service
   - CV: The level of E&M code submitted is not supported by documentation. (V122)
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

   For CPT Code 27096-50:
   - 197 – Precertification/authorization/notification absent.
   - Per TX rule 134.600 Pre-Auth is required. If services have been preauthorized resubmit the bill with authorization info for reconsideration. (XF06)

Issues

Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

On reconsideration, the explanation of benefits from the insurance carrier dated January 31, 2014 indicates that the insurance carrier paid the full billed amount of $415.88 for disputed CPT code27096-50. Therefore, this code will not be considered further in this dispute.

The insurance carrier denied disputed CPT code 99215 with claim adjustment reason code 150 – "Payer deems the information submitted does not support this level of service," and "CV: THE LEVEL OF E & M CODE SUBMITTED IS NOT SUPPORTED BY DOCUMENTATION. (V122)." 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 99215 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 comprehensive history; A comprehensive examination; Medical decision making of high 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, 40 minutes are spent face-to-face with the patient and/or family.

The 1995 Documentation Guidelines for Evaluation & Management Services is an appropriate Medicare guideline to determine the documentation requirements for the service in dispute. Review of the documentation finds the following:

- Documentation of the Comprehensive History:
  - "An *extended* [History of Present Illness (HPI)] consists of four or more elements of the HPI." Documentation found eight elements of the HPI, thus meeting this element.
  - "A *complete* [Review of Systems (ROS)] inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional body systems. [Guidelines require] at least ten organ systems must be reviewed." Documentation found 13 systems reviewed. This element was met.
  - "A *complete* [Past Family, and/or Social History (PFSH)] is … a review of two of the three history areas… [Guidelines require] at least one specific item from two of the three history areas must be documented for a complete PFSH." The documentation finds that two history areas were reviewed. This element was met.

The Guidelines state, "To qualify for a given type of history all three elements in the table must be

met." A review of the submitted documentation indicates that all three elements were met for a Comprehensive History, therefore this component of CPT Code 99215 was supported.

- Documentation of a Comprehensive Examination:
    - A "*comprehensive* [examination is] a general multi-system examination or complete examination of a single organ system." Guidelines indicate that eight or more systems should be examined. A review of the submitted documentation finds that an extended examination of three systems was documented. Therefore, this component of CPT Code 99215 was not met.
- Documentation of Decision Making of High Complexity:
    - *Number of diagnoses or treatment options* – Review of the submitted documentation finds that an established, worsening problem was presented to the examiner, meeting the documentation requirements of limited complexity. Therefore, this element was not met.
    - *Amount and/or complexity of data to be reviewed* – Review of the documentation finds that the requestor did not review additional data. The documentation does not support that this element met the criteria for high complexity of data reviewed.
    - *Risk of complications and/or morbidity or mortality* – Review of the submitted documentation finds that presenting problems include a chronic injury with mild exacerbation, which presents a moderate level of risk; no diagnostics were ordered; and prescription medication with a minor procedure were discussed, which presents a moderate level of risk. "The highest level of risk in any one category…determines the overall risk." The documentation supports that this element met the criteria for moderate risk.

  "To qualify for a given type of decision making, **two of the three elements … must be either met or exceeded**." A review of the submitted documentation supports that this component of CPT Code 99215 was not met.

Because only one component of CPT Code 99215 was met, the requestor failed to support the level of service required by 28 Texas Administrative Code §134.203. The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	October 23, 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, 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 MFDR 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.