



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

Medalart Occupational Management Inc

**Respondent Name**

Chubb Indemnity Co

**MFDR Tracking Number**

M4-14-2764-01

**Carrier's Austin Representative**

Box Number 17

**MFDR Date Received**

May 8, 2014

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "In disagreement with your EOB, the Level of Service of (claimants) visit included a comprehensive history, a comprehensive examination, and met two of the tree elements of medical decision making for High Complexity."

**Amount in Dispute:** \$388.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The office visit, using CPT code 99205, was billed in addition to several other procedures. There is no documentation that the Requestor spent 60 minutes face-to-face with the Claimant, as required by use of this CPT code, above and beyond all the other testing and procedures completed during the same visit."

**Response Submitted by:** Downs Stanford PC

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 9, 2014	99205	\$388.00	\$323.56

#### 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
  - W1 – Workers Compensation state fee schedule adjustment

## **Issues**

1. Did the requestor support level of service submitted?
2. What is applicable rule in relation to fee guidelines?
3. Is the requestor entitled to reimbursement?

## **Findings**

1. The carrier denied the disputed services 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 a new patient. The American Medical Association (AMA) CPT code description for 99205 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 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, 60 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
  - o 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 three chronic conditions, thus meeting this component.
  - o 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 fourteen systems, this component was met.
  - o 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 three areas. This component was 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 sixteen body/organ systems: head, chest, abdomen, neck, each extremity, constitutional, skin, eyes, eyes/nose/throat (ENT), respiratory, cardiovascular and neurological, psychological and lymphatic. This component was met.
- The Medical Complexity was "High Severity."
- Documentation of time. The Centers for Medicare/Medicaid Services, <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html>, states, "If the physician documents total time and suggest that counseling or coordination care dominates (more than 50%) the encounter, time may determine level of service." Review of the submitted documentation supports the requirements of a comprehensive exam are met even without the documentation of time.

The Division finds the carrier's denial is not supported. The disputed service will be reviewed per applicable rules and fee guidelines.

2. Procedure code 99205, service date January 9, 2014, 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 3.17 multiplied by the geographic practice cost index (GPCI) for work of 1.014 is 3.21438. The practice expense (PE) RVU of 2.35 multiplied by the PE GPCI of 1.013 is 2.38055. The malpractice RVU of 0.26 multiplied by the malpractice GPCI of 0.803 is 0.20878. The sum of 5.80371 is multiplied by the Division conversion factor of \$55.75 for a MAR of \$323.56.
3. The total allowable reimbursement for the services in dispute is \$323.56. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$323.56. 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 \$323.56.

**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 \$323.56 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 20, 2014 Date
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**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.**