



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Emmanuel E. Ubinas-Brache, MD

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-14-3358-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

July 8, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am appealing these dates of services 04/08/14, 04/30/14, 05/14/14, 05/21/14, 06/04/14, because they have been denied several times due to the office visit notes not supporting the level of service for line item 99214.

However, I have enclosed the guidelines of components evaluation management E/M services. Therefore, please reconsider these claims and should be looked over again by the audit department because they contain all the information required for an office visit."

Amount in Dispute: \$1005.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 4/8/14, 4/30/14, 5/14/14, 5/21/14, and 6/4/14. The requester billed E&M code 99214 on the dates above. Each of the documents associated with the use of the code are deficient in meeting the clearly defined criteria established by the AMA CPT coding guidelines for E&M episodes. For this reason Texas Mutual declined to issue payment. However, Texas Mutual did issue payment for the DWC-73 of 6/4/14. (Attachment)

No additional payment is due."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 8 – June 4, 2014	99214, 99080	\$1005.00	\$168.90

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 §133.203 defines the medical fee guidelines for reimbursement of professional services.

3. 28 Texas Administrative Code §129.5 sets out the procedures for providing and billing for Work Status Reports.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - From Explanation of Benefits dated 5/2/14, regarding date of service 4/8/14:
 - CAC-150 – Payer deems the information submitted does not support this level of service.
 - 890 – Denied per AMA CPT code description for level of service and/or nature of presenting problems.
 - From Explanation of Benefits dated 5/4/14, regarding date of service 4/30/14:
 - CAC-150 – Payer deems the information submitted does not support this level of service.
 - 890 – Denied per AMA CPT code description for level of service and/or nature of presenting problems.
 - From Explanation of Benefits dated 6/9/14, regarding date of service 5/14/14:
 - CAC-150 – Payer deems the information submitted does not support this level of service.
 - CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
 - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
 - 890 – Denied per AMA CPT code description for level of service and/or nature of presenting problems.
 - From Explanation of Benefits dated 6/9/14, regarding date of service 5/21/14:
 - CAC-150 – Payer deems the information submitted does not support this level of service.
 - CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
 - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
 - 890 – Denied per AMA CPT code description for level of service and/or nature of presenting problems.
 - From Explanation of Benefits dated 7/3/14, regarding date of service 6/4/14:
 - CAC-P12 – Workers’ Compensation Jurisdictional Fee Schedule Adjustment.
 - CAC-150 – Payer deems the information submitted does not support this level of service.
 - CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
 - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
 - 725 – Approved non network provider for Texas Star Network claimant per Rule 1305.153 (C).
 - 890 – Denied per AMA CPT code description for level of service and/or nature of presenting problems.

Issues

1. Did the requestor support the level of service for CPT Code 99214 for each date of service as required by 28 Texas Administrative Code §134.203?
2. Is the requestor entitled to reimbursement?

Findings

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 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. [emphasis added]

The 1997 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare guideline to determine the documentation requirements for the service in dispute. Required components for documentation of CPT Code 99214 are as follows:

- Documentation of the Detailed History:
 - “An *extended* [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.”

- “An *extended* [Review of Systems (ROS)] inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems. [Guidelines require] the patient’s positive responses and pertinent negatives for two to nine systems to be documented.”
- “A *pertinent* [Past Family, and/or Social History (PFSH)] is a review of the history area(s) directly related to the problem(s) identified in the HPI. [Guidelines require] at least one specific item from any three history areas [(past, family, or social)] to be documented.”

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

- Documentation of a Detailed Examination:
 - A “*detailed examination* ... should include at least six organ systems or body areas. For each system/area selected, performance and documentation of at least two elements [of the General Multi-System Examination table]. Alternatively, a detailed examination may include performance and documentation of at least twelve elements ... in two or more organ systems or body areas.”
- Documentation of Decision Making of Moderate 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 4/8/14, the submitted documentation supports that the requestor provided a review of five (5) elements of HPI, a review of two (2) systems, and one (1) area of PFSH. This meets the documentation requirements for a Detailed History. The submitted report shows that the requestor included performance and documentation of five (5) elements of the General Multi-System Examination table, which does not meet the criteria for a Detailed Examination. The submitted documentation supports that the requestor met the criteria for documentation of Decision Making of Moderate Complexity. **Because the documentation indicates that the requestor met two (2) of the required key components of CPT Code 99214, did support this level of service.**

For date of service 4/30/14, the submitted documentation supports that the requestor provided a review of five (5) elements of HPI, a review of two (2) systems, and one (1) area of PFSH. This meets the documentation requirements for a Detailed History. The submitted report shows that the requestor included performance and documentation of three (3) elements of the General Multi-System Examination table, which does not meet the criteria for a Detailed Examination. The submitted documentation does not support that the requestor met the criteria for documentation of Decision Making of Moderate Complexity. **Because the documentation indicates that the requestor met only one (1) of the required key components of CPT Code 99214, the requestor did not support this level of service.**

For date of service 5/14/14, the submitted documentation supports that the requestor provided a review of two (2) elements of HPI, a review of one (1) systems, and one (1) area of PFSH. This does not meet the documentation requirements for a Detailed History. The submitted report shows that the requestor included performance and documentation of two (2) elements of the General Multi-System Examination table, which does not meet the criteria for a Detailed Examination. The submitted documentation does not support that the requestor met the criteria for documentation of Decision Making of Moderate Complexity. **Because the documentation indicates that the requestor did not meet any of the required key components of CPT Code 99214, the requestor did not support this level of service.**

For date of service 5/21/14, the submitted documentation supports that the requestor provided a review of four (4) elements of HPI, a review of two (2) systems, and one (1) area of PFSH. This meets the documentation requirements for a Detailed History. The submitted report shows that the requestor included performance and documentation of three (3) elements of the General Multi-System Examination table, which does not meet the criteria for a Detailed Examination. The submitted documentation does not support that the requestor met the criteria for documentation of Decision Making of Moderate Complexity. **Because the documentation indicates that the requestor met only one (1) of the required key components of CPT Code 99214, the requestor did not support this level of service.**

For date of service 6/4/14, the submitted documentation supports that the requestor provided a review of four (4) elements of HPI, a review of two (2) systems, and one (1) area of PFSH. This meets the documentation

requirements for a Detailed History. The submitted report shows that the requestor included performance and documentation of three (3) elements of the General Multi-System Examination table, which does not meet the criteria for a Detailed Examination. The submitted documentation does not support that the requestor met the criteria for documentation of Decision Making of Moderate Complexity. **Because the documentation indicates that the requestor met only one (1) of the required key components of CPT Code 99214, the requestor did not support this level of service.**

2. Procedure code 99214, service date April 8, 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 1.5 multiplied by the geographic practice cost index (GPCI) for work of 1.014 is 1.521. The practice expense (PE) RVU of 1.41 multiplied by the PE GPCI of 1.013 is 1.42833. The malpractice RVU of 0.1 multiplied by the malpractice GPCI of 0.803 is 0.0803. The sum of 3.02963 is multiplied by the Division conversion factor of \$55.75 for a MAR of \$168.90. Therefore, the recommended reimbursement amount for this date of service is \$168.90.

Because the requestor did not support the level of service for CPT Code 99214 for dates of service 4/30/14, 5/14/14, 5/21/14, and 6/4/14, no reimbursement is recommended for these dates of service.

Review of the submitted documentation finds that CPT Code 99080 for date of service 6/4/14 was paid per medical fee guidelines found in 28 Texas Administrative Code §129.5 (i). Therefore, no reimbursement is recommended for this code.

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 \$168.90.

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 \$168.90 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	<u>Laurie Garnes</u>	<u>January 6, 2015</u>
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.