



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 North Dallas

Respondent Name

Starbucks Corporation

MFDR Tracking Number

M4-15-0199-01

Carrier's Austin Representative

Box Number 44

MFDR Date Received

September 15, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached dates of services 10/9/13 and 10/24/13 were not paid in full.

These dates were originally denied as 'services not provided or authorized by network provider.' **We spoke to the adjuster...on 9/20/13 before we even started treating the patient and again on 5/14/14 confirming this patients claim is NOT IN NETWORK. ...**

These dates were resubmitted on 2/17/14, and we **never got a response, EOB.** These were **resubmitted yet again on 5/14/14.** The EOB for date of service 10/9/13 requested the original claim, so it was resubmitted with it as requested. **We have yet to receive a response or EOB from the carrier since 5/14/14.** Date 10/24/13 was however reviewed as a reconsideration, but **denied as a duplicate which doesn't make much sense considering the original EOB stated the cpt code 99080 'lacks information'.** All information pertaining to this code has been submitted.

Not to mention, the work status reports and office visits are required PER TDI REQUIREMENTS and encouraged PER ODG GUIDELINES..."

Amount in Dispute: \$204.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on September 23, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 9, 2014 October 24, 2014	Office Visit (99214) & Work Status Report (99080) Work Status Report (99080)	\$204.92	\$15.00

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 §133.3 sets out the requirements for communication between insurance carriers and health care providers.
3. 28 Texas Administrative Code §129.5 sets out the procedures for submitting and billing for a Work Status Report by a treating or referral doctor.
4. 28 Texas Administrative Code §133.210 defines the requirements for documentation submitted with medical billing.
5. 28 Texas Administrative Code §134.203 provides the fee guidelines for billing and reimbursing professional medical services.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
For date of service 10/9/13:
 - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attach
 - 16 – Disallowed, charges will be reviewed upon receipt of supporting info. Such as reports, notes, or invoice. Resubmit with original bill.For date of service 10/24/13:
 - 16 - Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attach
 - 18 – This line was previously processed and is a duplication/duplicate charge

Issues

1. Did the requestor provide the required documentation for the disputed office visit for date of service 10/9/13?
2. Did the requestor provide the required documentation for the disputed Work Status Reports for dates of service 10/9/13 and 10/24/13?
3. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. The insurance carrier denied the charges stating, "Claim/service lacks information or has submission/billing error(s) which is needed for adjudication." 28 Texas Administrative Code §133.210 states, "(b) When submitting a medical bill for reimbursement, **the health care provider shall provide required documentation in legible form**, unless the required documentation was previously provided to the insurance carrier or its agents. (c) In addition to the documentation requirements of subsection (b) of this section, medical bills for the following services shall include the following supporting documentation: (1) **the two highest Evaluation and Management office visit codes** for new and established patients: **office visit notes/report satisfying the American Medical Association requirements for use of those CPT codes**" [emphasis added].

Further, 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 submitted documentation also supports that office notes were submitted with the billing.

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. Review of the documentation

finds the following:

- 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.” Documentation finds a review of 4 elements of HPI was performed. Therefore, this condition was met.
 - “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.” Documentation found one system (musculoskeletal) reviewed. This element was not met.
 - “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 documentation does not support that any history areas were reviewed. This element was not 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 only one element was met for a Detailed History, therefore this component of CPT code 99214 was not supported.

- Documentation of a Detailed Examination:
 - A “*detailed* [examination] ...should include at least six organ systems or body areas...[or] at performance and documentation of at least twelve elements [from the Musculoskeletal Examination table].” Documentation indicates that only 1 system (musculoskeletal) was examined and only 4 elements from the Musculoskeletal Examination table were discussed, although the results were not included. This component of CPT code 99214 was not met.
- Documentation of Decision Making of Moderate Complexity:
 - *Number of diagnoses or treatment options* – Review of the submitted documentation finds that there were no new diagnoses presented, but that established diagnoses for 2 body areas were stable, meeting the documentation requirements of limited complexity. Moderate complexity in this component requires multiple diagnoses or management options. Therefore, this element was not met.
 - *Amount and/or complexity of data to be reviewed* – Review of the documentation finds that the requestor obtained and reviewed records from someone other than the patient (“neuro”). Moderate complexity in decision-making requires moderate complexity of data. The documentation supports that this element met the criteria for moderate complexity of data reviewed.
 - *Risk of complications and/or morbidity or mortality* – Review of the submitted documentation finds that presenting problems include two stable, chronic conditions which present a low level of risk. No diagnostic procedures were ordered. Management options discussed were to continue physical therapy, which presents a low 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 low complexity/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 99214 was met.

Because no components of CPT code 99214 was met, the requestor failed to support the level of service required by 28 Texas Administrative Code §133.210 and §134.203 for date of service 10/9/13.

2. 28 Texas Administrative Code §129.5 states, “(d) The doctor shall file the Work Status Report: (1) after the initial examination of the employee, regardless of the employee’s work status; (2) **when the employee experiences a change in work status** or a substantial change in activity restrictions; and (3) on the schedule requested by the insurance carrier (carrier), its agent, or the employer requesting the report through its carrier, which shall not to exceed one report every two weeks and which shall be based upon the doctor’s scheduled appointments with the employee” [emphasis added].

Review of the submitted documentation for the Work Status Report filed 10/9/13 does not support that this date of service was the initial examination. The office note submitted with the report states, “His work status will remain the same,” so there was no documented change in work status or activity restrictions. The documentation does not support that the report was filed on a schedule requested by the carrier, its agent, or the employer through its carrier. The documentation requirements for filing the Work Status Report for date of service 10/9/13 were not met.

Review of the submitted documentation for the Work Status Report filed 10/24/13 supports that there was a

substantial change in the activity restrictions for the injured employee. Therefore, the documentation requirements for filing the Work Status Report for date of service 10/24/13 were met.

3. Because the documentation requirements for CPT code 99214 and 99080 for date of service 10/9/13 were not met, the requestor is not eligible for reimbursement of these services.

28 Texas Administrative Code §129.5 (i) states, in relevant part, "Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section ... The amount of reimbursement shall be \$15." The documentation submitted supports that the Work Status Report billed for date of service 10/24/13 met the requirements of this section. Therefore, the requestor is entitled to reimbursement of \$15.00 for this service.

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 \$15.00.

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 \$15.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Laurie Garnes
Medical Fee Dispute Resolution Officer

February 5, 2015
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.