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
Safety National Casualty Corporation

MFDR Tracking Number
M4-15-1303-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 29, 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. All of this documentation was sent in for reconsideration to the carrier several times. This is an approved case with all other claims being paid in full. Treating provider, Dr. Lopez has outlined key components regarding patient's initial visit with our office. Please see attached patient account statement showing all other claims being paid in a timely manner. 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: $255.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our supplemental response for the above referenced medical fee dispute resolution is as follows: Gallagher Bassett stands by the denial of the charges. Please see below for rationale behind our denial.

CV has upheld the denial of the 99204. Please note – the original review had previously recommended the documentation supported level 99202. Upon re-review, their recommendation down code was bumped up to level 99203. The payment recommendation remained as $0.00 as Texas is a no down code state.

A comprehensive history requires a chief complaint, extended history of present illness, a review of systems that is directly related to the problem and a social history. The documentation is lacking a review of systems that includes all additional body system, a complete past history, and is lacking any family history.

A detailed history requires chief complaint, extended history of present illness, problem pertinent system review extended to include a review of a limited number of additional systems, pertinent past, family and or social history directly related to the patient's problem.

Based on the above description, the documentation more closely reflects a detailed history.

Regarding the examination, a comprehensive examination can by a comprehensive general multisystem examination or a complete examination of a single organ system. This component is not met.

For a comprehensive general multisystem exam, the provider should document on 8 of the following organ systems:

Eyes, ears/nose/mouth & throat, cardiovascular, respiratory, gastrointestinal, genitourinary, musculoskeletal, skin, neurological, psychiatric, hematological/lymphatic/immunological.

For a single system exam, the documentation must meet the 1997 documentation guidelines for evaluation and management services for the single system exam that the provider is performing.

The documentation does not meet a comprehensive multisystem organ exam or any of the comprehensive exams for single systems in the 1997 guidelines.

A detailed examination should include an extended examination of the affected body areas and other symptomatic or related organ systems. Based upon the above description of the documentation, the provider meets the description of a detailed exam.

The provider must meet a moderate level of medical decision making for a 99204 and the provider has met that so that is not in dispute."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 10, 2014	New Patient Office Examination (99204)	$255.04	$0.00

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 §134.203 sets out the procedures for determining the fee schedule for professional services.
3. 28 Texas Administrative Code §133.240 sets out the procedures for paying or denying medical bills.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 15 – (150) Payer deems the information does not support this level of service.
   - ZE10 – Not defined as required in 28 Texas Administrative Code §133.240.

Issues

1. Did the requestor support the level of service for CPT Code 99204 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 a new patient.

   The American Medical Association (AMA) CPT code description for 99204 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 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, 45 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 Comprehensive 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 found seven 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 systems. [Guidelines require] at least ten organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented." Documentation found one system (musculoskeletal) reviewed. This element was not met.
- "A *complete* [Past Family, and/or Social History (PFSH)] is a review of … all three of the PFSH history areas." The documentation finds that one history area (Past History) was 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 99204 was not supported.

- Documentation of a Comprehensive Examination:
  - A "*comprehensive* examination [for a single organ system] …should include performance of all elements [of the Musculoskeletal Examination table]." A review of the submitted documentation finds that only six of the fifteen elements were documented. Therefore, this component of CPT Code 99204 was not met.
- Documentation of Decision Making of Moderate Complexity:
  - *Number of diagnoses or treatment options* – Review of the submitted documentation finds that a new problem to the examiner was presented with additional workup planned, meeting the documentation requirements of Extensive complexity. Therefore, this element was exceeded.
  - *Amount and/or complexity of data to be reviewed* – Review of the documentation finds that the requestor ordered evaluations by two other specialists. Moderate complexity in decision-making requires moderate complexity of data. The documentation supports that this element met the criteria for limited complexity of data reviewed.
  - *Risk of complications and/or morbidity or mortality* – Review of the submitted documentation finds that presenting problems include one worsening, chronic injuries, which present a moderate level of risk; pain management and physical therapy were ordered. "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 99204 was met.

Because only one component of CPT Code 99204 was met, the requestor failed to support the level of service required by 28 Texas Administrative Code §134.203.

2. For the reasons stated above, the services in dispute are not eligible for reimbursement.

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

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	March 17, 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.