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
Sergio J. Alvarado, MD

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-15-2044-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 4, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Attach is a claim for dispute. I submitted the appeal to Texas Mutual, who denied it due to the information submitted does not support this level of service. I then noted that the diagnosis code was corrected from 338.4 to the compensable diagnosis code of 724.4 since the visit was related to the work injury. I also attached copies of the medical record for review and to assist in reprocessing the claim for payment. I am attaching copies of the appeals submitted to Texas Mutual for review and to assist in getting this dispute paid."

Amount in Dispute: $200.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 8/14/14. The requestor billed Texas Mutual E/M code 99214 for the date above. Texas Mutual declined to issue payment absent documentation that meets 2 of the 3 criteria for that code per the following.

1. Under History, there is one chronic problem – pain. There is no documented review of systems (ROS) or past medical, family, social history PFSH). No ROS and no PFSH equates to Problem Focused.

2. Under Exam, there is no documented physical exam with findings. This equates to incomplete.

3. Under Medical Decision Making, the number of diagnoses or treatment options is 2 points. (Nothing in column B and only 2 points in column C.)

Under Medical Decision Making, The Amount and/or Complexity of Data Reviewed equates to 0 points.

Under Risk of Complications and/or Morbidity or Mortality, the level of risk for Diagnostic Procedures Ordered equates to none as none were ordered.

Under Risk of Complications and/or Morbidity or Mortality, the level of risk for Management Options equates to Moderate for Prescription drug management.

4. The AMA requires 2 of the following 3 criteria be met to qualify the 99214: Detailed History, Detailed Exam, or Moderate Decision Making. The requestor's documentation shows an incomplete history and no exam. And no payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 14, 2014	Evaluation & Management, established patient (99214)	$200.00	$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. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 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.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 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.
   - 891 – No additional payment after reconsideration.
   - CAC-18 – Exact duplicate claim/service.
   - 878 – Appeal (request for reconsideration) previously processed. Refer to Rule 133.250(H).

Issues

1. Did the requestor support the level of service for CPT Code 99214 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 1995 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." Review of the submitted documentation finds that the requestor addressed five (5) elements of the HPI, meeting the requirement for this element.
     - "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." Review of the submitted documentation finds that the requestor reviewed only the musculoskeletal system, which does not meet the requirement for this element.

- "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)] must be documented…" Review of the submitted documentation finds that the requestor did perform a review of relevant past history and social history, meeting the criteria for this element.

The Guidelines state, "To qualify for a given type of history, **all three elements in the table must be met.**" Because only two (2) of the elements were met, the requestor did not meet the documentation requirements for this category.

- Documentation of a Detailed Examination:
  - A "*detailed examination* – an extended examination of the affected body area(s) and other symptomatic or related organ system(s)." The Guidelines state, "Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of 'abnormal' without elaboration is insufficient." Review of the submitted documentation finds that the requestor performed only an examination of the constitutional system, which does not meet the documentation requirements for this category.
- 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 diagnostic testing recommended are taken into account. Review of the submitted documentation finds that the requestor addressed an established, worsening problem, which meets the documentation requirements for limited complexity.
  - *Amount and/or complexity of data to be reviewed* – This can include diagnostic tests ordered or reviewed and data reviewed from another source. There were no tests ordered or information from other sources obtained/reviewed. Therefore, the documentation indicates minimal complexity of data to be reviewed.
  - *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." Review of the submitted documentation finds that the management options included drug therapy requiring intensive monitoring for toxicity, which meets the criteria for a high risk level.

"To qualify for a given type of decision making, **two of the three elements … must be either met or exceeded**." Review of the submitted documentation supports medical decision making of low complexity overall.

Because none of the components of CPT Code 99214 were 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	April 15, 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.