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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health Center, PA

Respondent Name
ACE American Insurance Company

MFDR Tracking Number
M4-15-2069-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
March 10, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "**ADOPTION OF NEW RULE 134.202**

TREATING PHYSICIANS WITHIN THE WORKERS' COMPENSATION SYSTEM ARE RESPONSIBLE FOR MAINTAINING ADMINISTRATIVELY TIME CONSUMING FUNCTIONS SUCH AS, RESEARCHING COMPENSABILITY, ESTABLISHING RELATIONSHIPS WITH CARRIERS, AND EVAULATING RETURN TO WORK. BECAUSE OF THESE ADDED RESPONSIBILITIES IN WORKERS' COMPENSATION, IT IS APPROPRIATE THAT THE EVALUATION AND MANAGEMENT CODES BE UPGRADED TO A HIGHER LEVEL OF REIMBURSEMENT.

I have received partial payment for … the date of service listed above. The level of service is being disputed. The level of visit meets the requirements that are specified in the AMA CPT book.

99214 for the evaluation and management of an established patient, which requires **two** of these three components:

- A detailed histoy;
- A detailed examination;
- Medical decision making of moderate complexity.

Dr. Starkey performed a detailed history and examination and determined patient needed a referral to a surgeon for follow up care for inguinal hernia."

Amount in Dispute: $216.00

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 March 17, 2015. 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.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 28, 2014	Evaluation & Management, established patient (99214)	$216.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 fee guidelines for billing and reimbursing professional medical services provided on or after March 1, 2008.
3. 28 Texas Administrative Code §133.240 sets out the procedures for payment and denial of medical bills.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - 15 – (150) Payer deems the information submitted does not support this level of service.
   - P12 – Not defined as required by 28 Texas Administrative Code §133.240.

Issues

1. What is the correct fee guideline for reviewing the disputed services?
2. Was the insurance carrier's denial of the disputed services supported?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor referenced 28 Texas Administrative Code §134.202 to support a higher level of service in their position statement. 28 Texas Administrative Code §**134.203** (a) states, "(2) This section applies to professional medical services provided on or after March 1, 2008. (3) For professional services provided between August 1, 2003 and March 1, 2008, §134.202 of this title (relating to Medical Fee Guideline) applies." Review of the submitted documentation finds that the dispute involves professional services provided on November 28, 2014. Therefore, the correct fee guideline for reviewing the disputed service is 28 Texas Administrative Code §134.203.

2. The insurance carrier denied the disputed services with claim adjustment code 15 – "(150) Payer deems the information submitted does not support this level of service." The requestor is seeking reimbursement for an office visit for the evaluation and management of an established patient – CPT Code 99214. 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, as evidenced by the statement "Worker's Comp Initial Visit."

   Further, 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 provider reviewed four elements of HPI, which meets the documentation requirements for an extended HPI.
    - "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 provider reviewed two systems, meeting the documentation requirements for an extended ROS.
    - "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…" A review of the submitted documentation finds that the provider reviewed all areas of PFSH, exceeding the documentation requirements for a pertinent PFSH.

  The Guidelines state, "To qualify for a given type of history, **all three elements in the table must be met.**" Documentation finds that this component of CPT Code 99214 was met.
- 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" [emphasis added]. Review of the submitted documentation finds that the provider met the requirements for a limited examination of two body areas or organ systems. This component of CPT Code 99214 was not met.
- 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 provider reviewed a new problem with no additional workup planned. This meets the documentation requirements for moderate complexity.
    - *Amount and/or complexity of data to be reviewed* – This can include diagnostic tests ordered or reviewed and data reviewed from another source. The submitted documentation finds that no tests were ordered or reviewed and no information was obtained by old records or a party other than the patient. This does not meet the criteria for moderate complexity.
    - *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." The documentation finds that the presenting problem is an acute uncomplicated injury, no diagnostic procedures were ordered, and over-the-counter drugs were recommended. This does not meet the documentation requirements of moderate complexity.

  "To qualify for a given type of decision making, **two of the three elements … must be either met or exceeded**." Because only one element was met, this component of CPT Code 99214 was not supported.

Because only one component of CPT Code 99214 was met and the patient type was inconsistent, the requestor failed to support the level of service required by 28 Texas Administrative Code §134.203. Therefore, the insurance carrier's denial was supported.

3. Because the insurance carrier's denial was supported, no further reimbursement is recommended.

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

	Laurie Garnes	May 27, 2015
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, 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 MFDR 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.