



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

GREGORY P. ENNIS, MD

**Respondent Name**

TEXAS MUTUAL INSURANCE CO

**MFDR Tracking Number**

M4-15-2328-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

MARCH 27, 2015

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "EcCare did submit follow up narrative injury reports (64) to Texas Mutual as evidenced by the enclosed fax receipts. These narrative reports are design specific to meet the 1997 Documentation Guidelines for Evaluation and Management Services for each individual E & M related CPT code as is required by 28 TAC 134.203 (b)(1). Please also note that Per rule 133.210 'Medical Documentation' paragraph (e); 'It is the insurance carrier's obligation to furnish its agents with any documentation necessary for the resolution of a medical bill. The Division considers any medical billing information or documentation possessed by one entity to be simultaneously possessed by the other.' EcCare did also submit a from DWC-73 Work Status Report in the form and manner described in 129.5 of TAC, as evidenced by the transmission logs enclosed. Texas Mutual multiple denial reasons are in err."

**Amount in Dispute:** \$209.32

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The requestor billed code 99214 but did not substantiate the criteria necessary to use the code. The History was expanded problem focused. The exam was problem focused, and the complexity of medical decision making was straightforward. Although the requestor documented the claimant was in the center for 69 minutes with a minimum of 25 being face to face with staff, there is no documentation describing the content of counseling or coordination of care nor did it document that more than half of the time was counseling or coordination of care. No payment is due for code 99214. The requestor billed for a DWC73 with code 99080-73. However, the report showed no change in work status or activity restriction from the DWC73 of 11/22/14. (Attachment) No payment is due."

**Response Submitted By:** Texas Mutual Insurance Co.

## **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 6, 2015	CPT Code 99214 Office Visit	\$194.32	\$0.00
	CPT Code 99080-73 Work Status Report	\$15.00	\$0.00
TOTAL		\$209.32	\$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 §134.204, effective March 1, 2008, sets out medical fee guidelines for workers' compensation specific services.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
4. 28 Texas Administrative Code §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - CAC-18-Exact duplicate claim/service.
  - 224-Duplicate charge.

### **Issues**

1. Does the documentation support billing code 99214? Is the requestor entitled to reimbursement?
2. Does the documentation support billing code 99080-73? Is the requestor entitled to reimbursement?

### **Findings**

1. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

CPT code 99214 is defined as "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."

A review of the submitted medical report does not support the documentation requirement which require at least 2 of the 3 key components; therefore, the Division refers to the Medicare's Evaluation and Management Services Guide to determine if the report supports "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."

Per Medicare's Evaluation and Management Services Guide, "When counseling and/or coordination of care dominates (more than 50 percent of) the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting, floor/unit time in the hospital, or Nursing Facility), time is considered the key or controlling factor to qualify for a particular level of E/M services. If the level of service is reported based on counseling and/or coordination of care, the total length of time of the encounter should be documented and the record should describe the counseling and/or activities to coordinate care. For example, if 25 minutes was spent face-to-face with an established patient in the office and more than half of that time was spent counseling the patient or coordinating his or her care, CPT code 99214® should be selected."

Medicare's *Claims Processing Policy Manual, 100-04, subsection (B) Selection of Level Of Evaluation and Management Service* "Instruct physicians to select the code for the service based upon the content of the service. The duration of the visit is an ancillary factor and does not control the level of the service to be billed unless more than 50 percent of the face-to-face time (for non-inpatient services) or more than 50 percent of the floor time (for inpatient services) is spent providing counseling or coordination of care as described in subsection C."

Medicare's *Claims Processing Policy Manual, 100-04, subsection (C) Selection Of Level Of Evaluation and Management Service Based On Duration Of Coordination Of Care and/or Counseling* "Advise physicians that when counseling and/or coordination of care dominates (more than 50 percent) the face-to-face physician/patient encounter or the floor time (in the case of inpatient services), time is the key or controlling factor in selecting the level of service. In general, to bill an E/M code, the physician must complete at least 2 out of 3 criteria applicable to the type/level of service provided. However, the physician may document time spent with the patient in conjunction with the medical decision-making involved and a description of the coordination of care or counseling provided. Documentation must be in sufficient detail to support the claim."

A review of the office visit report states "The patient spent a total of 69 minutes in the center, with more than a minimum of 25 minutes of that time being face to face with medical staff and providers." The requestor wrote "[Claimant] was given after care instructions, and acknowledged understanding to me...I had instructive conversation with the patient and explained what he could perform as to light duty tasks." The Division finds that the requestor did not support that the 25 minutes spent were face-to-face with the physician; therefore, the requestor has not supported billing CPT code 99214.

2. CPT code 99080-73 is defined as "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form."

28 Texas Administrative Code §134.204 (l) states "The following shall apply to Work Status Reports. When billing for a Work Status Report that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section, refer to §129.5 of this title (relating to Work Status Reports)."

28 Texas Administrative Code §129.5(i)(1) states "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 or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be \$15. A doctor shall not bill in excess of \$15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section."

28 Texas Administrative Code §129.5 (d)(1) and (2) states "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."

The respondent states in the position summary that "the report showed no change in work status or activity restriction from the DWC73 of 11/22/14. (Attachment) No payment is due." In support of the position the

respondent submitted a copy of the November 22, 2014 work status report that showed no change in activity restrictions to support billing the January 6, 2015 work status report in accordance with 28 Texas Administrative Code §129.5 (d)(2); therefore, reimbursement cannot be recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that 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

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

06/10/2015  
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.**