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
Hand and Wrist Center of Houston

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-15-2509-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
April 13, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Your organization denied this claim, stating that the information submitted does not support the level of service billed. According to the CMS Evaluation and Management services guide, for a level 5 (High Complexity) the following are required: **detailed history, detailed exam, and high complexity Medical Decision-Making.** If you look through the clinical notes on this visit, you will find that the notes include **all three of the necessary critera.** Please review attached notes. Furthermore we request immediate and full payment of this claim. Because this clean claim was incorrectly underpaid without a request for additional information, under Texas Law you now owe Hand and Wrist Center of Houston, P.A. 100% of billed charges, less the amount previously paid plus the patient responsibility, for a **balance due and owing of $218.55.**"

Amount in Dispute: $218.55

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 11/21/2014. The requester billed code 99214 for the date above. The History is expanded problem focused; the Exam is expanded problem focused; and the Complexity of medical decision making is straightforward.

No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 21, 2014	Evaluation & Management, established patient (99214)	$218.55	$168.95

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.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment 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.
   - 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.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 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. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
3. 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 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 found six (6) elements of HPI were reviewed, thus meeting the documentation requirements for this component.
     - "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 five (5) systems reviewed. This component was

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 supports that all PFSH areas were reviewed. This component was 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 supports a Detailed History, therefore this component of CPT Code 99214 was met.

- Documentation of a Detailed Examination:
  - A "*detailed* [examination] …should include performance and documentation of at least twelve elements [of the Musculoskeletal Examination table]." A review of the submitted documentation finds that twelve (12) elements were documented. Therefore, this component of CPT Code 99214 was 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 were stable, meeting the documentation requirements of minimal complexity. Therefore, this element was not met.
  - *Amount and/or complexity of data to be reviewed* – Review of the documentation finds that the requestor ordered no diagnostic testing and did not review the reports from another provider or obtain history from a person other than the patient. Moderate complexity in decision-making requires moderate complexity of data. The documentation supports that this element met the criteria for minimal/low complexity of data reviewed.
  - *Risk of complications and/or morbidity or mortality* – Review of the submitted documentation finds that presenting problems include one stable, chronic injury, which present a low level of risk; no diagnostic procedures were ordered; and physical therapy was continued. "The highest level of risk in any one category…determines the overall risk." The documentation supports that this element met the criteria for low 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 not met.

Because two components of CPT Code 99214 were met, the requestor supported the level of service required by 28 Texas Administrative Code §134.203.

2. Procedure code 99214, service date November 21, 2014, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 1.5 multiplied by the geographic practice cost index (GPCI) for work of 1.014 is 1.521. The practice expense (PE) RVU of 1.41 multiplied by the PE GPCI of 1.004 is 1.41564. The malpractice RVU of 0.1 multiplied by the malpractice GPCI of 0.939 is 0.0939. The sum of 3.03054 is multiplied by the Division conversion factor of $55.75 for a MAR of $168.95.
3. The total allowable reimbursement for the services in dispute is $168.95. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $168.95. This amount is recommended.

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 $168.95.

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 $168.95 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	May 15, 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.