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
James S. Garrison, MD

Respondent Name
New Hampshire Insurance Company

MFDR Tracking Number
M4-15-2539-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 13, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to Gallagher Bassett on September 4, 2014, this request was in response to a $660.78 reduction of the $1025.73 for the EMG/NCV Designated Doctor Referred Exam performed on April 16, 2014. Unfortunately our request was denied and we are seeking the balance owed to us.

The denial reason(s) per EOB are: Workers Compensation fee schedule adjustment. Designated Doctor Exams are billed according to DWC rule 134.204 and in accordance with labor code 408.004, 408.0041, and 408.151."

Amount in Dispute: $364.95

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier has previously responded to this dispute on 5/5/15. Carrier maintains its position as outlined in the original response.

Coventry stands by the pricing and the denial of code 99204.

Per CPT-All 3 of the following Key Components would need to be satisfied in the documentation to support a 99204:

A Comprehensive History would be needed, which consists of all 3 elements of:
*4 History of Presenting Illness' (HPI) AND
*10 Review of Systems (ROS) AND
*3 Past Family, Social History (PFSH).
--This key component has not been satisfied.

A Comprehensive Examination would be needed.
For a further explanation, consult the 1997 Documentation Guidelines for a Comprehensive level examination.
Or
For a further explanation, consult the 1995 Documentation Guidelines for a Comprehensive level examination.
Or
For a further explanation, consult the Evaluation and Management section of the CPT book.
--This key component has not been satisfied

AND Medical Decision Making of Moderate Complexity, this key component has not been satisfied.
2 of the following 3 elements of MDM would need to be supported:
and type of diagnosis (Problem Points) Amount of and complexity of data reviewed (Data Points) Risk (Table of Risk) –This key component has not been satisfied

For the rest of the charges:
95886 [(.86 * 1.014) + (1.67 * 1.013) + (.04 * .803)] * 55.75 = $144.72 * 2 = $289.44
95911 [(2.50 * 1.014) + (3.66 * 1.013) + (.15 * .803)] *55.75 = $354.74

DMEPOS Fee Schedule
DME14
A4556 $13.28 * 125% = $16.60"

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 16, 2014	Evaluation & Management, new patient (99204) Needle Electromyography (95886) Nerve Conduction Studies, 9-10 (95911) Electrodes (A4556)	$364.95	$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.
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:
   - 15 – (150) Payer deems the information submitted does not support this level of service
   - P12 – (P12) Workers' Compensation jurisdictional fee schedule adjustment
   - P1 – Not defined as required in 28 Texas Administrative Code §133.240

Issues

1. Is the insurance carrier's reason for denial of payment for CPT Code 99204 supported?
2. What is the Maximum Allowable Reimbursement (MAR) for the payable services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed CPT Code 99204 with claim adjustment reason code "15 – (150) Payer deems the information submitted does not support this level of service." 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 [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. 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." Documentation found six 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 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." The submitted documentation indicates that only one element was met for a Comprehensive History, therefore this component of CPT Code 99204 was not supported.
- Documentation of a Comprehensive Examination:
    - A "*comprehensive* [examination should include] a general multi-system examination or complete examination of a single organ system … [Guidelines state] a general multi-system examination should include findings about 8 or more of the 12 organ systems." A review of the submitted documentation finds that a limited examination was performed on two organ systems. 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 reviewed radiology tests. Moderate complexity in decision-making requires moderate complexity of data. The documentation supports that this element met the criteria for low complexity of data reviewed.
    - *Risk of complications and/or morbidity or mortality* – Review of the submitted documentation finds that presenting problems include an acute complicated injury, which present a moderate level of risk; electromyography and nerve conduction studies 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. Therefore, the insurance carrier's denial of payment for this code was supported.

2. Procedure code 95886, service date April 16, 2014, represents a professional service with reimbursement determined per §134.203(c), which states, in relevant part, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83 … (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year." 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 0.86 multiplied by the geographic practice cost index (GPCI) for work of 1.014 is 0.87204. The practice expense (PE) RVU of 1.67 multiplied by the PE GPCI of 1.013 is 1.69171. The malpractice RVU of 0.04 multiplied by the malpractice GPCI of 0.803 is 0.03212. The sum of 2.59587 is multiplied by the Division conversion factor of $55.75 for a MAR of $144.72 at 2 units is $289.44.

   Procedure code 95911, service date April 16, 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 2.5 multiplied by the geographic practice cost index (GPCI) for work of 1.014 is 2.535. The practice expense (PE) RVU of 3.66 multiplied by the PE GPCI of 1.013 is 3.70758. The malpractice RVU of 0.15 multiplied by the malpractice GPCI of 0.803 is 0.12045. The sum of 6.36303 is multiplied by the Division conversion factor of $55.75 for a MAR of $354.74.

   Procedure code A4556, service date April 16, 2014, represents a supply or equipment with reimbursement determined per §134.203(d), which states, "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule." The fee listed for this code in the Medicare DMEPOS fee schedule is $13.28. 125% of this amount is $16.60.

3. The total allowable for the disputed services is $660.78. The insurance carrier paid $660.78. Therefore, 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 28, 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.