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, M.D., P.A.

Respondent Name
Standard Fire Insurance Company

MFDR Tracking Number
M4-15-2729-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
April 27, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… the amount of $861.29 is due and payable."

Amount in Dispute: $861.29

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our bill audit company has determined additional monies are owed in the amount of $502.75 Interest in the amount of 16.72 has been issued. Both additional monies owed and interest was issued 7/1/15."

Response Submitted by: Gallagher Bassett Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 12 – 14, 2014	Evaluation & Management (99205) Evaluation & Management (99215) Work Status Reports (99080) Radiology (71020, 72050, 73130) Laboratory Test (81002)	$861.29	$19.37

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 §133.240 sets out the procedures for payment and denial of medical bills.
3. 28 Texas Administrative Code §129.5 sets out the procedures for work status reports.
4. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   For date of service 6/12/14 (CPT 99205, 99080, 71020, 73130) and date of service 6/14/14 (CPT 72050):
   - 20 – (206) National Provider Identifier – Missing
   For date of service 6/14/14 (CPT 99215, 81002):
   - 15 – (150) Payer deems the information submitted does not support this level of service.
   For date of service 6/14/14 (CPT 99080):
   - No denial reason found in submitted documentation

Issues

1. Is the insurance carrier's reason for denial of payment supported for CPT codes 99205, 99080, 71020, and 73130 on date of service June 12, 2014 and CPT code 72050 on date of service June 14, 2014?
2. Is the insurance carrier's reason for denial of payment supported for CPT codes 99215 on date of service June 14, 2014?
3. Is the insurance carrier's reason for denial of payment supported for CPT codes 81002 on date of service June 14, 2014?
4. Is the insurance carrier's denial of payment supported for CPT codes 99080 on date of service June 14, 2014?
5. What is the reimbursement amount for the disputed services?
6. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed CPT codes 99205, 99080, 71020, and 73130 on date of service June 12, 2014 and CPT code 72050 on date of service June 14, 2014 with claim adjustment reason code 20 (206) – "National Provider Identifier – Missing." Review of the submitted documentation finds that the insurance carrier did not maintain this denial after submission to Medical Fee Dispute Resolution. The insurance carrier's denial reason for these services is not supported. These disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. The insurance carrier denied disputed CPT code 99215, on date of service June 14, 2014, 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) 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 99215 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 comprehensive history; A comprehensive examination; Medical decision making of high complexity** [emphasis added]. 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, 40 minutes are spent face-to-face with the patient and/or family.

   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 Comprehensive 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 five elements of HPI addressed, thus meeting this requirement.
    - "A *complete* [Review of Systems (ROS)] inquires about the system(s) directly related to the problem(s) identified in the HPI, *plus* all additional body systems. [Guidelines require] at least ten organ systems [to 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/or Social History (PFSH)] is a review of two … of the PFSH history areas. [Guidelines require that] at least one specific item from two of the three history areas [(past, family, or social)] must be documented." Documentation found that past and social histories were addressed, thus meeting this element.

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 indicates that two elements were met for a Comprehensive History; therefore this component of CPT Code 99215 was not supported.

- Documentation of the Comprehensive Examination:
    - A *comprehensive* examination should include performance of "at least two bullets from **each** of nine body systems/areas" for a general multisystem examination or "at least one bullet in **each** box with an unshaded border **AND** every bullet in **each** box with a shaded border" for a single system examination. A review of the submitted documentation found that documentation does not support that this component of CPT Code 99215 was met.
- Documentation of Decision Making of High Complexity:
    - *Number of diagnoses or treatment options* – Review of the submitted documentation found that there were no new diagnoses presented, but that three established diagnoses were improved. This element did not meet the criteria for high complexity.
    - *Amount and/or complexity of data to be reviewed* – Review of the documentation found that the requestor ordered one diagnostic urinalysis. The documentation supports that this element does not meet the criteria for high complexity of data reviewed.
    - *Risk of complications and/or morbidity or mortality* – Review of the submitted documentation found that presenting problems include three improving injuries, one minimal diagnostic procedure was ordered; and over-the-counter medication options were discussed. "The highest level of risk in any one category…determines the overall risk." The documentation supports that this element did not meet the criteria for high risk.

"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 does not support that this component of CPT Code 99215 was met.

The division finds that the requestor failed to support the level of service required by 28 Texas Administrative Code §134.203. Therefore, the insurance carrier's denial of this service is supported no further reimbursement is recommended for this service.

3. The insurance carrier denied disputed CPT code 81002, on date of service June 14, 2014, with claim adjustment reason code 15 (150) – "Payer deems the information submitted does not support this level of service."

   The American Medical Association (AMA) CPT code description for 81002 is:

Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy

Review of the submitted documentation finds this service documented on page 4 of the office visit narrative. The insurance carrier's denial reason for this service is not supported. This disputed service will therefore be reviewed per applicable Division rules and fee guidelines.

4. The insurance carrier denied disputed CPT code 99080, on date of service June 14, 2014, but submitted documentation does not find a denial reason for this code. 28 Texas Administrative Code §133.240(f)(17) requires the explanation of benefits to include:

   (G) adjustment reason code that conforms to the standards described in §133.500 and §133.501 of this title if total amount paid does not equal total amount charged;
   (H) explanation of the reason for reduction/denial if the adjustment reason code was included under subparagraph (G) of this paragraph…

   The division finds that the insurance carrier's denial of payment for this service is not supported. This disputed service will therefore be reviewed per applicable Division rules and fee guidelines.

5. 28 Texas Administrative Code §134.203(c) states,

   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. The Division conversion factor for 2014 is $55.75.

   For CPT code 99205 on June 12, 2014, the relative value (RVU) for work of 3.17 multiplied by the geographic practice cost index (GPCI) for work of 1.000 is 3.170000. The practice expense (PE) RVU of 2.35 multiplied by the PE GPCI of 0.916 is 2.152600. The malpractice (MP) RVU of 0.26 multiplied by the MP GPCI of 0.816 is 0.212160. The sum of 5.534760 is multiplied by the Division conversion factor of $55.75 for a MAR of $308.56.

   For CPT code 71020 on June 12, 2014, the RVU for work of 0.22 multiplied by the GPCI for work of 1.000 is 0.220000. The PE RVU of 0.63 multiplied by the PE GPCI of 0.916 is 0.577080. The MP RVU of 0.02 multiplied by the MP GPCI of 0.816 is 0.016320. The sum of 0.813400 is multiplied by the Division conversion factor of $55.75 for a MAR of $45.35.

   For CPT code 73130 on June 12, 2014, the RVU for work of 0.17 multiplied by the GPCI for work of 1.000 is 0.170000. The PE RVU of 0.75 multiplied by the PE GPCI of 0.916 is 0.687000. The MP RVU of 0.02 multiplied by the MP GPCI of 0.816 is 0.016320. The sum of 0.873320 is multiplied by the Division conversion factor of $55.75 for a MAR of $48.69.

   For CPT code 72050 on June 14, 2014, the RVU for work of 0.31 multiplied by the GPCI for work of 1.000 is 0.310000. The PE RVU of 1.04 multiplied by the PE GPCI of 0.916 is 0.952640. The MP RVU of 0.04 multiplied by the MP GPCI of 0.816 is 0.032640. The sum of 1.295280 is multiplied by the Division conversion factor of $55.75 for a MAR of $72.21.

   28 Texas Administrative Code §134.203(e) states,

   The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows:

(1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service;

For CPT code 81002 on June 14, 2014, the fee listed in the Medicare Clinical Fee Schedule is $3.49. This amount multiplied by 125% gives a total MAR of $4.37.

28 Texas Administrative Code §129.5(i) states, in relevant part,

> 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.

For CPT code 99080-73 on June 12, 2014, the reimbursement amount is $15.00.

For CPT code 99080-73 on June 14, 2014, the reimbursement amount is $15.00.

6. 28 Texas Administrative Code §134.203(h) states:

> When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the:
> (1) MAR amount;
> (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or
> (3) fair and reasonable amount consistent with the standards of §134.1 of this title.

Recommended reimbursement amounts are as follows:

Date of service	CPT Code	MAR	Requested	28 TAC 134.203(h)	Insurance Paid	Recommended
6/12/14	99205	$308.56	$358.30	$308.56	$323.56	$0.00
6/12/14	71020	$45.35	$102.00	$45.35	$48.91	$0.00
6/12/14	73130	$48.69	$47.08	$47.08	$47.08	$0.00
6/12/14	99080-73	$15.00	$15.00	$15.00	$15.00	$0.00
6/14/14	72050	$72.21	$68.20	$68.20	$68.20	$0.00
6/14/14	81002	$4.37	$13.00	$4.37	$0.00	$4.37
6/14/14	99080-73	$15.00	$15.00	$15.00	$0.00	$15.00

The total recommended amount is $19.37.

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 $19.37.

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 $19.37 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	January 11, 2016
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.