



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

Healthcare Rehab Group

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-15-3627-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

July 6, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our provider has reviewed his notes and is standing firm that all documentation is correct for this level of service."

Amount in Dispute: \$655.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Review of the documentation for both dates using the 1995 E&M scoring sheet from Novitas shows an expanded problem focused history, no examination, and low complexity medical decision making."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: January 12 & 26, 2015; Evaluation & Management, established patient (99214) Work Status Report (99080); \$655.00; \$342.50

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 §133.203 defines the medical fee guidelines for reimbursement of professional services.
3. 28 Texas Administrative Code §129.5 sets out the procedures for providing and billing for Work Status

Reports.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CAC-P12 – Workers’ Compensation jurisdictional fee schedule adjustment.
 - 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.
 - 248 – DWC-73 in excess of the filing requirements; no change in work status and/or restrictions; reimbursement denied per Rule 129.5
 - 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. What are the criteria for documenting the level of service for CPT Code 99214?
2. Were the insurance carrier’s reasons for denial of reimbursement for CPT Code 99214 supported?
3. Were the insurance carrier’s reasons for denial of reimbursement for CPT Code 99080 supported?
4. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed CPT Codes 99214 with claim adjustment reason code “CAC-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 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 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.”
 - “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.”

- “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 Guidelines state, “To qualify for a given type of history, **all three elements in the table must be 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.”

- 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 treatment recommended are taken into account.
- *Amount and/or complexity of data to be reviewed* – This can include diagnostic tests ordered or reviewed and data reviewed from another source.
- *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.”

“To qualify for a given type of decision making, **two of the three elements ... must be either met or exceeded.**”

2. For date of service January 12, 2015, the submitted documentation supports that the requestor provided a review of five (5) elements of HPI, a review of four (4) systems, and one (1) area of PFSH. This meets the documentation requirements for a Detailed History. The submitted report shows that the requestor included an extended examination of five (5) organ systems, which meets the criteria for a Detailed Examination. The submitted documentation does not support that the requestor met the criteria for documentation of Decision Making of Moderate Complexity. Because the documentation indicates that the requestor met two (2) of the required key components of CPT Code 99214, the requestor did support this level of service. The insurance carrier’s denial for this CPT Code on this date of service is not supported.

For date of service January 26, 2015, the submitted documentation supports that the requestor provided a review of five (5) elements of HPI, a review of five (5) systems, and one (1) area of PFSH. This meets the documentation requirements for a Detailed History. The submitted report shows that the requestor included an extended examination of four (4) organ systems, which meets the criteria for a Detailed Examination. The submitted documentation does not support that the requestor met the criteria for documentation of Decision Making of Moderate Complexity. Because the documentation indicates that the requestor met two (2) of the required key components of CPT Code 99214, the requestor did support this level of service. The insurance carrier’s denial for this CPT Code on this date of service is not supported.

3. The insurance carrier denied disputed CPT Codes 99080 with claim adjustment reason code “248 – DWC-73 IN EXCESS OF THE FILING REQUIREMENTS; NO CHANGE IN WORK STATUS AND/OR RESTRICTIONS; REIMBURSEMENT DENIED PER RULE 129.5.” 28 Texas Administrative Code §129.5 (d) and (f) define when a Work Status Report (DWC073) are to be filed:

(d) 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; and
- (3) on the schedule requested by the insurance carrier (carrier), its agent, or the employer requesting the report through its carrier, which shall not to exceed one report every two weeks and which shall be based upon the doctor's scheduled appointments with the employee...

(f) In addition to the requirements under subsection (d), the treating doctor shall file the Work Status Report with the carrier, employer, and employee within seven days of the day of receipt of:

- (1) functional job descriptions from the employer listing available modified duty positions that the employer is able to offer the employee as provided by §129.6(a) of this title (relating to Bona Fide Offers of Employment); or
- (2) a required medical examination doctor's Work Status Report that indicates that the employee can return to work with or without restrictions.

The documentation submitted does not find that the requestor substantiated that the Work Status Reports for the disputed dates of service were filed in accordance with 28 Texas Administrative Code §129.5 (d) or (f). Payment of this service is addressed in subsection 28 Texas Administrative Code §129.5 (i), which 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. 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...

Therefore, the insurance carrier's denial of CPT Code 99080 for the dates of service in dispute is supported and no further reimbursement can be recommended for these codes.

4. Procedure code 99214 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. The Division conversion factor for 2015 is \$56.20.

For CPT Code 99214 on January 12, 2015, the relative value (RVU) for work of 1.50 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 1.527000. The practice expense (PE) RVU of 1.43 multiplied by the PE GPCI of 1.009 is 1.442870. The malpractice RVU of 0.10 multiplied by the malpractice GPCI of 0.772 is 0.077200. The sum of 3.047070 is multiplied by the Division conversion factor of \$56.20 for a MAR of \$171.25.

For CPT Code 99214 on January 12, 2015, the relative value (RVU) for work of 1.50 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 1.527000. The practice expense (PE) RVU of 1.43 multiplied by the PE GPCI of 1.009 is 1.442870. The malpractice RVU of 0.10 multiplied by the malpractice GPCI of 0.772 is 0.077200. The sum of 3.047070 is multiplied by the Division conversion factor of \$56.20 for a MAR of \$171.25.

5. The total MAR for the disputed services is \$342.50. The insurance carrier paid \$0.00. Therefore an additional reimbursement of \$342.50 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 \$342.50.

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 \$342.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	July 29, 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, 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.