



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

Elite Healthcare Fort Worth

Respondent Name

Ace American Insurance Co

MFDR Tracking Number

M4-16-0458-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

October 21, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "(Treating physician) has outlined key components regarding the visits... Also, carrier did not pay according to the authorization for physical therapy. Patient was approved for 2 units 97140, 2 units 97112, and 4 units 97110. All other office visits have been paid in full without any discrepancies. Office visits are recommended to be medically necessary."

Amount in Dispute: \$371.11

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor billed for an office visit utilizing CPT code 99213 on the date of service 12/9/14. Ongoing evaluation is included in the treatment that is being provided. The provider would be expected to perform a basic evaluation when seeing a patient for therapy. No documentation supports that there were any additional services provided outside of this expected minimal evaluation. On the same day, Requestor also billed for CPT code 97140. However, on the original billing, the documentation does not support that this service was performed. Therefore, payment for the service denied. Requestor billed for an office visit utilizing CPT code 99214 on the date of service 12/16/14. The documentation/narrative from (treating physician) does not support that level of service."

Response Submitted by: Downs ♦ Stanford, PC

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Rows include dates from December 9, 2014 to December 16, 2014 and corresponding CPT codes (99213, 97140, 99214) and amounts (\$371.11, \$112.33).

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 reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 150 – Payer deems the information submitted does not support this level of service
 - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
 - B12 – Services not documented in patients’ medical records
 - W3 – Request for reconsideration

Issues

1. Is the carrier’s denial reason(s) supported?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services 99214 with claim adjustment reason code 150 – “Payer deems the information submitted does not support this level of service.” 28 Texas Administrative Code §134.203(b) states,

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;
- Submitted code 99214, date of service December 16, 2014. “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.” Review of the submitted medical record finds;

History

- Status of chronic conditions – 1 condition
- History of present illness elements – Brief
- Review of systems – none
- Past medical, family, social history areas - none

Requirements of code (Detailed) not met.

Examination

- Body area – 1 (extremity)

Medical Decision Making – Low

Complexity – Straight forward

Time – not documented

The carrier’s denial is supported as insufficient information to support that required elements of the code (Detailed) was found.

The insurance carrier denied submitted code 99214 – “Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes” as B12 – “Services not documented in patients’ medical records”.

Review of Medicare Claims Processing Manual, Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services, 20.2 - Reporting of Service Units With HCPCS; "Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.3B, Documentation Requirements for Therapy Services, indicates that the amount of time for each specific intervention/modality provided to the patient is not required to be documented in the Treatment Note. **However, the total number of timed minutes must be documented.**

Review of the submitted medical documentation finds;

- Manual therapy (97140), 2 units

The insurance carrier's denial reason is supported as the total timed minutes was not found within submitted documentation. Additional reimbursement cannot be recommended.

2. The carrier denied submitted code 99213 was denied as 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." The carrier states in their position statement, "Requestor billed for an office visit utilizing CPT code 99213 on the date of service 12/9/14. Ongoing evaluation is included in the treatment that is being provided. The provider would be expected to perform a basic evaluation when seeing a patient for therapy. No documentation supports that there were any additional services provided outside of this expected minimal evaluation." Per Rule 134.203(b) insufficient evidence was found to support within the applicable Medicare billing policy to support this denial. The service in dispute will be reviewed per applicable fee guideline.

3. 28 TAC 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 (date of service yearly conversion factor)

The maximum allowable reimbursement is calculated as (DWC conversion factor / Medicare conversion factor) x Participating Amount = MAR or $(55.75 / 35.8228) \times \$72.18 = \$112.33$. 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 \$112.33.

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 \$112.33 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

November , 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, 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.