



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

Professional Emergency Service Association of Desoto

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-16-0983-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

December 16, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Texas Mutual did incorrectly deny the billing of 99215 stating that the documentation did not support the services billed. Enclosed please find a copy of the narrative report which includes a complete history as well as detailed musculoskeletal examination two elements that are required to bill a level four subsequent visit."

Amount in Dispute: \$235.97

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed code 99215 for the referenced date. Texas Mutual declined to issue payment. The History, reflecting an extended HPI and complete ROS, was incomplete for PFSH and also the HPI was related to one chronic problem only. Further, the Physical Examination, focused sole on the spine, was Problem Focused."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 20, 2015	Evaluation & Management, established patient (99215)	\$235.97	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
- 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 problem.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 724 – No additional payment after a reconsideration of services.

Issues

Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

The insurance carrier denied disputed CPT code 99215 with claim adjustment reason code CAC-150 – “PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE,” 225 – “THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE LEVEL OF SERVICE BEING BILLED...,” and 890 – “DENIED PER AMA CPT CODE DESCRIPTION FOR LEVEL OF SERVICE AND/OR NATUR OF PRESENTING PROBLEM.” 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 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. 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 an appropriate 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 four or more elements of the HPI.” Documentation found 7 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 body 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 2 systems reviewed. This element was not met.
 - “A *complete* [Past Family, and/or Social History (PFSH)] is ... a review of two of the three history areas... [Guidelines require] at least one specific item from two of the three history areas must be documented for a complete PFSH.” The documentation found that 2 history areas were reviewed. This element 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 indicates that 2 elements were met for a

Comprehensive History, therefore this component of CPT Code 99215 was not supported.

- Documentation of a Comprehensive Examination:
 - A “*comprehensive* [examination is] a general multi-system examination or complete examination of a single organ system.” A single system examination best represents the documented examination. Guidelines indicate that a comprehensive examination of a single system “should include performance of all elements identified by a bullet (•), whether in a shaded or unshaded box. Documentation of every element in each box with a shaded border and at least one element in a box with an unshaded border is expected.” A review of the submitted documentation does not support that the requirements for a comprehensive examination were met. Therefore, this component of CPT Code 99215 was not met.
- Documentation of Decision Making of High Complexity:
 - *Number of diagnoses or treatment options* – Review of the submitted documentation found that an established, worsening problem was presented to the examiner. Therefore, this element was not met.
 - *Amount and/or complexity of data to be reviewed* – Review of the documentation found that the requestor reviewed a radiology report. The documentation does not support that this element met 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 a chronic injury with mild exacerbation, which presents a moderate level of risk; no diagnostics were ordered; and prescription medication was ordered, which presents a moderate level of risk. “The highest level of risk in any one category...determines the overall risk.” The documentation does not support that the requirements for high complexity of risk was met.

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

Because none of the required components of CPT Code 99215 were met, the requestor failed to support the level of service required by 28 Texas Administrative Code §134.203. The insurance carrier’s denial reason is supported. Additional reimbursement cannot be 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	January 15, 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.