



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Elite Healthcare Fort Worth

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-16-1745-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

February 16, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Treating provider has attached dictation for each office visit."

Amount in Dispute: \$508.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "1. Texas Mutual has elected to pay code 99213, date 3/11/15.

2. The billing of code 99361, date 3/11/15, is not consistent with Rule 134.204(e)(4)(A). There is nothing about this document submitted with code 99361 indicating the treating doctor participated in the case management activity.

3. The billing of code 99361, date 5/15/15, is not consistent with Rule 134.204(e)(4)(A). There is nothing about this document submitted with code 99361 indicating the treating doctor participated in the case management activity.

4. The documentation of the 99214 E&M visit, date 5/19/15, does not meet the cpt criteria: the History is incomplete and the Exam is (sic) expanded problem focused."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 11 – May 19, 2015	Evaluation & Management, Established Patient (99213) Team Conference/Case Management (99361) Evaluation & Management, Established Patient (99214)	\$508.88	\$226.87

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 §133.240 sets out the procedures for payment or denial of a medical bill.
3. 28 Texas Administrative Code §134.203 defines the medical fee guidelines for reimbursement of professional services.
4. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
5. 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 his level of service.
 - 744 – Does not meet the definition of case management per DWC Rule 134.202 and/or 134.204.
 - 864 – E/M Services may be reported only if the patient’s condition requires a significant separately identifiable E/M service.
 - 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-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.

Issues

1. Did the insurance carrier support payment of disputed procedure code 99213 for date of service March 11, 2015?
2. What is the maximum allowable reimbursement (MAR) for procedure code 99213 for date of service March 11, 2015?
3. Did the insurance carrier deny procedure code 99361 for date of service March 13, 2015?
4. What is the MAR for procedure code 99361 for date of service March 13, 2015?
5. Is the denial of procedure code 99361 for date of service May 15, 2015 supported?
6. Did the requestor support the level of service for CPT Code 99214 as required by 28 Texas Administrative Code §134.203?
7. Is the requestor entitled to reimbursement of the disputed services?

Findings

1. In their position statement, the insurance carrier did not maintain their denial of procedure code 99213 for date of service March 11, 2015, stating that “Texas Mutual has elected to pay code 99213, date 3/11/15.” Review of the submitted documentation does not find an explanation of benefits to support the amount of this payment. Therefore, this service will be reviewed in accordance with the fee guidelines found in 28 Texas Administrative Code §133.203.
2. 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 2015 is \$56.20.

For procedure code 99213 on March 11, 2015, the relative value (RVU) for work of 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1.005 is 0.974850. The practice expense (PE) RVU of 1.01 multiplied by the PE GPCI of 0.995 is 1.004950. The malpractice (MP) RVU of 0.06 multiplied by the MP GPCI of 0.772 is 0.046320. The sum of 2.026120 is multiplied by the Division conversion factor of \$56.20 for a MAR of \$113.87.

3. The requestor is seeking reimbursement for procedure code 99361 for date of service March 13, 2015. Review of the submitted documentation does not find that this procedure code for this date of service was paid, reduced, or denied in accordance with 28 Texas Administrative Code §133.240.

4. 28 Texas Administrative Code §134.204(e)(4) states, in relevant part:

... Case management services shall be billed and reimbursed as follows:

(A) CPT Code 99361.

(i) Reimbursement to the treating doctor shall be \$113. Modifier "W1" shall be added.

Therefore, the MAR for the service in question is \$113.00.

5. The insurance carrier denied procedure code 99361 for date of service May 15, 2015 claim adjustment code 744 – “DOES NOT MEET THE DEFINITION OF CASE MANAGEMENT PER DWC RULE 134.202 AND/OR 134.204. 28 Texas Administrative Code §134.204(e) states that:

Case Management Responsibilities by the Treating Doctor is as follows:

(1) Team conferences and telephone calls shall include coordination with an interdisciplinary team.

(A) Team members shall not be employees of the treating doctor.

(B) Team conferences and telephone calls must be outside of an interdisciplinary program.

Documentation shall include the purpose and outcome of conferences and telephone calls, and the name and specialty of each individual attending the team conference or engaged in a phone call.

(2) Team conferences and telephone calls should be triggered by a documented change in the condition of the injured employee and performed for the purpose of coordination of medical treatment and/or return to work for the injured employee.

(3) Contact with one or more members of the interdisciplinary team more often than once every 30 days shall be limited to the following:

(A) coordinating with the employer, employee, or an assigned medical or vocational case manager to determine return to work options;

(B) developing or revising a treatment plan, including any treatment plans required by Division rules;

(C) altering or clarifying previous instructions; or

(D) coordinating the care of employees with catastrophic or multiple injuries requiring multiple specialties.

(4) Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity ...

Review of the submitted documentation does not find documentation for the service in question, as required by 28 Texas Administrative Code §134.204(e). Therefore, the insurance carrier’s denial for this service is supported.

6. The requestor is seeking reimbursement for procedure code 99214 for date of service May 19, 2015. The insurance carrier denied this service with claim adjustment codes CAC-150 – “PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE,” and 890 – “DENIED PER AMA CPT CODE DESCRIPTION FOR LEVEL OF SERVICE AND/OR NATURE OF PRESENTING PROBLEMS.”

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)] must 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 diagnostic testing 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.**"

For date of service May 19, 2015, the submitted documentation supports that the requestor provided a review of four (4) elements of HPI, a review of one (1) system, and no PFSH. This does not meet the documentation requirements for a Detailed History. The submitted report shows that the requestor included performance and documentation of an examination of the affected body area and one (1) other symptomatic area, which does meet the criteria for a Detailed Examination. The submitted documentation supports that the requestor met the criteria for documentation of Decision Making of Moderate Complexity. **Because the documentation indicates that the requestor met only one (1) of the required key components of CPT Code 99214, the requestor did not support this level of service.**

7. The division finds that the requestor is eligible to receive a reimbursement of \$226.87 for the disputed services. Submitted documentation finds that the insurance carrier paid \$0.00. Therefore, a reimbursement of \$226.87 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 \$226.87.

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 \$226.87 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	April 14, 2016 Date
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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.