



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

GREGORY P. ENNIS, MD

Respondent Name

NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number

M4-16-2844-02

Carrier's Austin Representative

Box Number 19

MFDR Date Received

May 16, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please review the entire narrative report to find the elements required for ROS, PFSH and HPI. In addition please review the exam score sheet attached demonstrating that an exam was performed meeting the level of service billed herein. This of course would meet the requirements of two of the three components of documentation required for subsequent visits."

Amount in Dispute: \$332.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "All 3 of the following Key Components would need to be satisfied in the documentation to support a 99205: . . . A Comprehensive Examination would be needed. . . . this key component has not been satisfied . . . AND Medical Decision Making of High Complexity. . . . This key component has not been satisfied — Moderate Complexity has been identified."

Response Submitted by: Flahive, Ogden & Latson, Attorneys At Law, P.C.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: June 17, 2015, Procedure Codes: 99205, 99080, 72110, 1160F, \$332.62, \$0.00

FINDINGS AND DECISION

This amended findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent. 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 the fee guideline for professional medical services.
3. 28 Texas Administrative Code §129.5 governs the filing of and payment for work status reports.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 15 – (150) PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE.
 - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUS
 - P300 – The amount paid reflects a fee schedule reduction. (P300)
 - 18 – Duplicate claim/service.
 - Z710 – The charge for this procedure exceeds the fee schedule allowance (Z710)
 - W4 – REQUEST FOR RECONSIDERATION.
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Did the requestor support that payment is due for services billed under procedure code 1160F?
2. Did the requestor support that payment is due for services billed under procedure code 99080?
3. Did the requestor support that payment is due for services billed under procedure code 99205?
4. Did the requestor support that payment is due for services billed under procedure code 72110?

Findings

1. The requestor's *Table of Disputed Services* lists procedure code 1160F—defined as “Review of medications by a prescribing practitioner documented in the medical record.”

28 Texas Administrative Code §133.307(c)(2) requires the requestor to provide the following information and records with the request for Medical Fee Dispute Resolution (MFDR):

(J) a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier . . .

(K) a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider . . . or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB.

Review of the submitted information finds no copies of a bill for the disputed service. Neither were any explanations or benefits found, nor convincing evidence of carrier receipt of the request for an EOB.

Based on the submitted information, the requestor has failed to support that this service was billed to the insurance carrier. Accordingly, this service is not eligible for medical fee dispute resolution. Payment cannot be recommended.

2. This dispute regards, in part, payment for a work status report, billed under procedure code 99080, with reimbursement subject to the provisions of 28 Texas Administrative Code §129.5(i), which states that “The amount of reimbursement shall be \$15.” Review of the submitted information finds that the insurance carrier has paid \$15.00 for this disputed service. No additional reimbursement is recommended.
3. The insurance carrier denied disputed evaluation and management services, billed under procedure code 99205, using 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)(1) requires that, for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply Medicare payment policies, including its coding; billing; correct coding (CCI) edits; modifiers; and other payment policies in effect on the date a service is provided, with any additions or exceptions as provided in the rules.

For the documentation of evaluation and management services, Medicare policy requires the use of the **1995 Documentation Guidelines for Evaluation and Management Services** and/or the **1997 Documentation Guidelines for Evaluation and Management Services**, available from the CMS website at: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf> and <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf>.

The definition of procedure code 99205 includes “evaluation and management of a new patient, requiring these 3 key components: 1) a comprehensive history; 2) a comprehensive examination; and 3) medical decision making of high complexity.”

Review of the submitted medical records finds that the first required key component, a comprehensive history, is documented.

However, the second key component—a comprehensive examination—is not found. To qualify as a comprehensive exam, the physician must perform a general multi-system examination or a complete exam of a single organ system. The submitted documentation does not support review of multiple systems, and definitely does not document the eight systems required to qualify as a general multi-system exam.

Next we consider if the documentation supports a complete review of a *single* system. Both sets of guidelines ('95 and '97) distinguish between **body areas** and **organ systems**. The back (including the spine, as was examined here) is defined as a *body area*. An extended examination of the affected body area(s) and related systems would qualify as a “detailed” examination—a lower level of service under the E/M Guidelines.

To qualify for the higher, “comprehensive,” level of service, both sets of Guidelines require a complete review of at least one entire organ system—such as the “musculoskeletal,” or possibly the “neurologic,” organ system. However, the findings in the medical record were limited to the affected body area—and were not complete with respect to any single entire organ system. While the requirements for “complete single organ system examinations” are less specific in the 1995 guidelines than the bulleted lists found in the 1997 guidelines, the provider did not document the requirements for a “complete examination of a single organ system” under either set of guidelines. Therefore, the Division finds the provider has not met the second key component of the definition of code 99205, regarding a comprehensive examination.

Lastly, the third key component—medical decision making of high complexity—is also not found. The number of diagnoses determined and treatment options reviewed were not extensive. The risk of complications, morbidity and/or mortality were not documented as high. When considered in regard with the amount and complexity of diagnostic data reviewed, a decision making level of “high complexity” is not supported; the requestor has failed to meet the third required key component of evaluation and management code 99205.

As all three of the key components in the definition of code 99205 are required to be met in order to qualify for the level of service billed, the insurance carrier’s denial reason is supported. The submitted documentation does not support the service as billed. Reimbursement cannot be recommended.

4. This dispute regards professional medical services with reimbursement subject to 28 Texas Administrative Code §134.203(c), which requires that:

To determine the MAR [Maximum Allowable Reimbursement] 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. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.
- (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 a conversion factor. The MAR is calculated by substituting the Division conversion factor. The applicable Division conversion factor for calendar year 2015 is \$56.20.

Reimbursement is calculated as follows:

- Procedure code 72110, service date June 17, 2015, represents a spinal X-ray with reimbursement subject to §134.203(c). For this procedure, the relative value (RVU) for work of 0.31 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.31558. The practice expense (PE) RVU of 1.02 multiplied by the PE GPCI of 1.009 is 1.02918. The malpractice RVU of 0.04 multiplied by the malpractice GPCI of 0.772 is 0.03088. The sum of 1.37564 is multiplied by the Division conversion factor of \$56.20 for a MAR of \$77.31.

The recommended allowance for procedure code 72110 is \$77.31. Review of the submitted explanations of benefits finds that the insurance carrier has paid \$77.31. Accordingly, no additional payment is 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 on 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 additional reimbursement for the services in dispute.

Authorized Signature

_____	<u>Grayson Richardson</u>	<u>July 7, 2016</u>
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.