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
ORTHOTEXAS PHYSICIANS AND SURGEONS

Respondent Name
OLD REPUBLIC INSURANCE CO

MFDR Tracking Number
M4-19-3956-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
APRIL 26, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Based on the diction attached Dr. Kouyoumjian spent 45 minutes face-to-face & more than 50% of that time with the patient counseling/coordinating care/treatment. See the attached documentation that supports the services provided. Please reprocess claim for payment immediately."

Amount in Dispute: $400.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No response was received.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 9, 2018	CPT Code 99204 Office Visit	$400.00	$261.30
	CPT Code 73080-RT X-Ray	$0.00	$0.00
	CPT Code 99080-73 Work Status Report	$0.00	$0.00
TOTAL		$400.00	$261.30

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 §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional 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.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - W3-Request for reconsideration.
   - CV- The level of E&M code submitted is not supported by the documentation.
   - Z257-CV-Reconsideration-No additional allowance recommended. This bill and submitted documentation have been re-evaluated by clinical validation. Submitted documentation does not support an additional allowance.
   - ZV31-After review of the bill and the medical record, this service is best described by 99203. Submitted documentation did not meet the 3 key components required for 99204. Lacking a comprehensive history and a comprehensive physical examination.

Issues

1. Did the insurance carrier respond to the medical fee dispute?
2. Does the documentation support billing CPT code 99204? Is the requestor due reimbursement?

Findings

1. The Austin carrier representative for Old Republic Insurance Co is White Espey, PLLC. White Espey, PLLC acknowledged receipt of the copy of this medical fee dispute on May 7, 2019. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information

   As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

2. The fee guidelines for disputed services are found in 28 Texas Administrative Code §134.203.

3. The insurance carrier denied reimbursement for the office visit , CPT code 99204, based upon the submitted information does not support level of service.

4. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."
4. CPT code 99204 is described as "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive 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, 45 minutes are spent face-to-face with the patient and/or family."

5. Medicare's *Evaluation and Management Services Guide*, "When counseling and/or coordination of care dominates (more than 50 percent of) the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting, floor/unit time in the hospital, or Nursing Facility), time is considered the key or controlling factor to qualify for a particular level of E/M services. If the level of service is reported based on counseling and/or coordination of care, the total length of time of the encounter should be documented and the record should describe the counseling and/or activities to coordinate care. For example, if 25 minutes was spent face-to-face with an established patient in the office and more than half of that time was spent counseling the patient or coordinating his or her care, CPT code 99214® should be selected."

6. Medicare's *Claims Processing Policy Manual, 100-04, Chapter 12, Section 30.6 titled Evaluation and*

Management Service Codes – General (Codes 99201-99499) subsection (B) Selection of Level Of Evaluation and Management Service states in part, "Instruct physicians to select the code for the service based upon the content of the service. The duration of the visit is an ancillary factor and does not control the level of the service to be billed unless more than 50 percent of the face-to-face time (for non-inpatient services) or more than 50 percent of the floor time (for inpatient services) is spent providing counseling or coordination of care as described in subsection C."

7. Medicare's *Claims Processing Policy Manual, 100-04, Chapter 12, Section 30.6 titled Evaluation and Management Service Codes – General (Codes 99201-99499) subsection (C) Selection Of Level Of Evaluation and Management Service Based On Duration Of Coordination Of Care and/or Counseling* states in part, "Advise physicians that when counseling and/or coordination of care dominates (more than 50 percent) the face-to-face physician/patient encounter or the floor time (in the case of inpatient services), time is the key or controlling factor in selecting the level of service. In general, to bill an E/M code, the physician must complete at least 2 out of 3 criteria applicable to the type/level of service provided. However, the physician may document time spent with the patient in conjunction with the medical decision-making involved and a description of the coordination of care or counseling provided. Documentation must be in sufficient detail to support the claim."

   A review of the submitted medical report indicates on page 6, under the Assessment and Plan, "At least 45 minutes was spent face to face with the patient with more than 50% of the encounter spent counseling and coordinating care with the pt." The requestor's documentation supports billing code 99204; therefore, reimbursement is recommended.

8. Per 28 Texas Administrative Code §134.203(c)(1)(2), "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. 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 following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2018 DWC conversion factor for this service is 58.31.

   The Medicare Conversion Factor is 35.9996

   Review of Box 32 on the CMS-1500 the services were rendered in Frisco, Texas; therefore, the locality will be based on the rate for "Rest of Texas".

   The Medicare participating amount for code 99204 is $161.32.

   Using the above formula, the MAR is $261.30. The respondent paid $0.00. As a result, the requestor is due $261.30.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $261.30.

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 $261.30 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		07/18/2019
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.