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
JEFFREY HIGGINBOTHAM, MD

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-19-4019-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 3, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DOS 11/7/2018 denied for the info submitted does not support this level of service. We billed this DOS as a 99214. Per the AMA CPT manual 9copies of guidelines attached), in order to bill a 99214 we need 2 of three of the following: a detailed history, a detailed examination, and medical decision making of moderate complexity. I have thoroughly audited the note from the date in question, and determined that we do in fact have a detailed history (6 HPI, Family, Medical & Social History, 11 ROS), a detailed exam (8 organ systems examined), and moderate decision making (multiple DX, Rx management for pain control, counseled on performed to ensure compliance with rx regimen). As the CPT guidelines state that I only need two out of three of the key elements and ALL THREE key elements were met, this code was correct as billed."

Amount in Dispute: $160.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill was denied for level of service. The provider submitted documentation to support 3 key components were met. According to the AMA CPT coding book description for 99214 also has to meet level of severity as moderate to severe in nature. Documentation from the provider on date of service 11/7/18 confirms there was no current changes from the last office visit. Medical Audit staff denied bill for level of severity for this reason."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 7, 2018	CPT Code 99214 Office Visit	$160.00	$160.00

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:
   - 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 problems.
   - CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

Does the documentation support billing CPT code 99214? Is the requestor due reimbursement?

Findings

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

   The insurance carrier denied reimbursement for the office visit , CPT code 99214, based upon reason code "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, "and "890-Dened per AMA CPT code description for level of service and/or nature of presenting problems."

   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."

   On the disputed date of service the requestor billed CPT code 99214 described as, "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."

   The division finds the documentation supports a detailed history and examination; therefore, the requestor supported billing CPT code 99214 and reimbursement is recommended.

2. 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 Austin, Texas; therefore, the locality will be based on the rate for "Austin, Texas".

The Medicare participating amount for code 99214 is $109.62.

Using the above formula, the MAR is $177.56. The requestor is seeking a lesser amount of $160.00. The respondent paid $0.00. As a result, the requestor is due $160.00.

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 $160.00.

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 $160.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		5/30/2019
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.