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
ELITE HEALTHCARE FORT WORTH

Respondent Name
XL INSURANCE AMERICA, INC.

MFDR Tracking Number
M4-19-4624-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 24, 2019

Response Submitted By
No response received

REQUESTOR'S POSITION SUMMARY

"TREATING PROVIDER HAS OUTLINED KEY COMPONENTS FOR THIS LEVEL OF SERVICE."

RESPONDENT'S POSITION SUMMARY

The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
October 18, 2018	Professional Medical Services: 99204	$267.26	$0.00

AUTHORITY

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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. The division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, receipt acknowledged July 2, 2019. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier has not responded. Accordingly, this decision is based on the information available at the time of review.
4. 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.

Findings

The Austin carrier representative for XL Insurance America, Inc. is Flahive, Odgen & Latson, Attorneys at Law, PC, who acknowledged receipt of a copy of the MFDR request on July 2, 2019. Pursuant to Rule §133.307(d)(1), if the division does not receive a response within 14 calendar days of dispute notification, the division may base its decision on the available information. To date, no response has been received. Consequently, this decision is based on the information available at the time of review.

The insurance carrier denied the disputed service with claim adjustment code 150 – "Payer deems the information submitted does not support this level of service."

The disputed service was billed with CPT code 99204, which represents an office visit for the evaluation and management of a *new* patient, which requires the following 3 key components:

1. A comprehensive history;
2. A comprehensive examination;
3. Medical decision making of moderate complexity.

Counseling and/or coordination of care is provided consistent with the nature of the problems and patient needs.

Rule §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 initiatives (CCI) edits … and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

Medicare policy requires use of Medicare's 1995 or 1997 evaluation and management documentation guidelines for determining the level of E&M service. Review of the submitted records finds the provider documented:

- 3 or more chronic conditions (wrist pain, swelling of digits, numbness in hand and fingers) with documentation of location, severity, timing, modifying factors, context and associated signs and symptoms sufficient to support a comprehensive history of present illness (HPI).
- Review of 11 systems noting that remainder are negative, sufficient to support a complete review of systems (ROS).
- While past medical history and social history are sufficiently noted, there is no mention of family history to support a *complete* past medical, family and social history (PFSH) as required by Medicare's documentation guidelines.
- While Medicare guidelines allow documentation of only 2 PFSH history areas for *established* patients, the guidelines require documentation of all 3 PFSH history areas for a *new* patient evaluation.
- Documentation of family history should include notation of the presence or absence of pertinent medical events in the patient's family — including diseases which may be hereditary or place the patient at risk.
- As this information is lacking from the submitted information, the PFSH qualifies as pertinent but not complete; therefore, the documented history elements altogether satisfy the requirements for a detailed history, but not a comprehensive one — as required by the definition of billing code 99204.
- With regard to the physical examination key component, a comprehensive exam requires a general, multi-system exam of 8 systems; or a complete exam of a single system.
- While more than 8 systems were reviewed in the history section, there was no notation to indicate any physical examination of those systems.
- The physical examination as documented was limited to the affected body area (wrist and arm) and related organ systems (musculature, joints, and nerves). The documentation is sufficient to support an expanded, problem focused exam, but not a detailed or a comprehensive exam as required by the definition of code 99204.
- With regard to the level of medical decision making, the record documents presenting problems including one or more chronic illnesses with mild exacerbation or progression sufficient to support a moderate level of risk.
- Only one diagnosis code was assigned; however, multiple treatment options were documented, including placing the patient on light duty, referral to specialists for diagnostic testing, as well as evaluation and assessment for pain management. The record is thus sufficient to support an extensive level of diagnosis and treatment options.

- Overall, the medical decision-making complexity was sufficient to support a moderate level of complexity as required by the definition of code 99204.
- Lastly, if the documentation indicates that counseling or coordination of care dominates more than 50% of the encounter, the overall time spent face-to-face may be used to determine the level of service.
- Typically, 45 minutes are spent face-to-face with the patient or family during this type of evaluation.
- However, review of the documentation finds no record of the stop or start times for the service, and no notation that counseling or coordination of care dominated more than 50% of the encounter.
- Accordingly, time cannot be used as a factor in this case to help determine the level of service.

Review of the submitted medical records has found the documentation sufficient to meet only one of the 3 key components required by the definition of code 99204. While the documentation does support medical decision making of moderate complexity, the record does not support a comprehensive history (no review of family history was found) or a comprehensive physical examination (the provider did not document examination of 8 or more systems or a complete exam of a single organ system). Lastly, no documentation was found of start and stop times or duration of the face-to-face time spent with the patient or family sufficient to support a determination based on time.

Because the provider did not meet the requirement to document all 3 key components, the disputed service does not meet the definition of billing code 99204. Accordingly, the insurance carrier's denial reasons are supported. Additional payment cannot be recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above, the division finds the requestor has not established that additional payment is due. As a result, the amount ordered is $0.00.

ORDER

In accordance with Texas Labor Code §413.031, based on the information submitted for review, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	August 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 Rule §133.307.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). The division must receive the request within twenty days of your receipt of this decision.

The request may be faxed, mailed or personally delivered either to the field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** together with any other information required by 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.