

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement for CPT code 99215.
- b. The request was received on July 26, 2002.

II. EXHIBITS

1. Requestor, Exhibit 1:
 - a. TWCC 60 and Letter Requesting Dispute Resolution
 - b. HCFA's
 - c. EOB
 - d. Medical Records
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit 2:
 - a. TWCC 60 and/or Response to a Request for Dispute Resolution
 - b. HCFA's
 - c. Audit summaries/EOB
 - d. Medical Records
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on December 16, 2002. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on December 16, 2002. The response from the insurance carrier was received in the Division on December 30, 2002. Based on 133.307 (i) the insurance carrier's response is timely.
4. Notice of Medical Dispute is reflected as Exhibit #3 of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: The requestor states in the correspondence dated September 20, 2001 that...
“...I am in receipt of your newest denial type. You have finally abstained from changing my service codes (only because I, along with many of my colleagues have pursued you legally for this), and now you say you don’t believe I did what I did, when I did it, and how I did it or how I documented it. You really are trying the patience of an industry!

I will point out on the attached progress note all of the body areas that were examined, and that I rendered an opinion regarding. If you will note there are 10 unique body sites I examined on this unfortunate patient. Additionally, you have interpreted my brevity of statement regarding these body areas to translate to a brief examination. Let me educate you poor ignorant clerks – this takes a lot of time, a lot of knowledge, experience, and patience with a patient that is in significant pain! This means I cannot just attach the patient and whip right through an exam so that I can bill it with a short visit; I have to spend time evaluating the injury and ALL related issues. Have I made this simple enough for you to understand?”

2. Respondent: The respondent states in the correspondence dated December 27, 2002 that... “...99215 The requestor billed for this level of service, without providing documentation consistent with the level billed. In addition, the requestor’s documentation does not qualify for reimbursement it did not demonstrate, express or implied, in any office note which two of the three components of management were being performed to warrant reimbursement. The carrier denied reimbursement because the documentation did not support the specific level billed as it is defined in the 1996 TWCC Medical Fee Guideline... A review of the dispute packet reveals there is no comprehensive history, no comprehensive physical examination, and the medical decision making – suggesting the claimant follow up with her family physician for arthritis and follow up with him (requestor) in one year—was not medical decision making high complexity.

The carrier maintains its position that no reimbursement is due...”

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is July 26, 2001.
2. Respondent denied the disputed date of service for F – T, N DOCUMENTATION DOES NOT SUPPORT THE SERVICE BILLED. CARRIERS MAY NOT REIMBURSE THE SERVICE AT ANOTHER BILLING CODE’S VALUE PER RULE 133.301(B). A REVISED CPT CODE ON DOCUMENTATION TO SUPPORT THE SERVICE MAY BE SUBMITTED.

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MARS (Maximum Allowable Reimbursement)	REFERENCE	RATIONALE:
07/26/01	99215	\$120.00	\$0.00	F – T, N	\$103.00	MFG, E/M GR (IV)(C)(2) CPT Descriptor	Treatment note for this date of service supports the level of service billed. Requestor has met two of the three components. Reimbursement is recommended.
Totals		\$120.00	\$0.00				The Requestor is entitled to reimbursement in the amount of \$103.00.

VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit \$103.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

This Order is hereby issued this 29th day of January 2003.

Marguerite Foster
 Medical Dispute Resolution Officer
 Medical Review Division

MF/mf