SOAH DOCKET NO. 453-03-2344.M4
MDR TRACKING NO. M4-02-4667-01

DONALD MALONE, M.D., PETITIONER	§	**BEFORE THE STATE OFFICE**
	§	
	§	
V.	§	
	§	**OF**
TEXAS MUTUAL INSURANCE COMPANY AND TEXAS WORKERS' COMPENSATION COMMISSION, RESPONDENTS	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Donald Malone, M.D., (Petitioner) appealed the findings and decision of the Texas Workers' Compensation Commission's (Commission) Medical Review Division (MRD) in MRD Docket No. M4-02-4667-01, which denied reimbursement for an office visit billed under CPT code 99214[1] provided to a workers' compensation claimant (Claimant).[2] The MRD decision upheld the denial of reimbursement by the Texas Mutual Insurance Company (Carrier) based on a finding that Petitioner failed to document that he billed the service under the proper CPT code. This decision finds Petitioner is entitled to the requested reimbursement.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

There were no contested issues of jurisdiction, notice or venue. Therefore, those matters are addressed in the findings of fact and conclusions of law without further discussion here.

The hearing in this matter convened and the record closed April 22, 2003, at the State Office of Administrative Hearings, 300 W. 15th Street, Austin, Texas, with Administrative Law Judge (ALJ) Ann Landeros presiding. Petitioner appeared *pro se* by telephone. Attorney Patricia Eads represented Carrier. The Commission did not participate in the hearing.

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[1] CPT Code 99214 is for "Office of other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. . . . Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family." Commission's Medical Fee Guideline. 28 TEX. ADMIN. CODE § 134.201 (for services rendered prior to September 1, 2002).

[2] Although the MRD appeal originally involved three disputed services, at the time of this hearing, the only remaining dispute issued was the March 21, 2002, office visit billed under CPT 99214.

II. DISCUSSION

A. Background Facts

Petitioner is an orthopedic surgeon. In July 2001, he operated on Claimant's ankle, which had been broken in an accident compensable under the Texas Workers' Compensation Act (Act). At the time of the compensable injury, Claimant's employer had workers' compensation insurance coverage with Carrier.

After the surgery, Petitioner continued to monitor the ankle's healing process in office visits that had tapered off to about once every other month by March 2002. Petitioner billed these office visits under CPT code 99214. After paying Petitioner's office visits under CPT code 99214 for visits from November 2001 through February 2002, Carrier rejected Petitioner's claim for reimbursement for a March 21, 2002, office visit. After the MRD upheld Carrier's denial, Petitioner appealed timely appealed the MRD decision.

B. The Claim And Denial

1. Documentation Of Service

Petitioner's one-page office visit note for the March 21, 2002, visit, contained the same sections and approximately the same information as the notes for the November 2001 through February 2002 visits. Each of the first four sections and two of the latter sections (the chief complaint, history of present illness, review of symptoms, past medical history, x-rays, and assessment) contained a one-line summary. The physical examination section read:

> Physical examination today reveals the patient is a well developed white male. He is able to ambulate without support. His strength and range of motion continue to improve. He has a well-healed surgical wound. His alignment and stability is good. His skin looks normal, vascular system looks stable. I don't see any lymph node swelling. He has normal orientation and affect.

In the Plan section, Petitioner wrote:

> With this patient at this point in time he is going to go ahead and return to normal duties. We will check him back again in about six weeks. I have discussed the risks and complications. He will give me a call back if he has any problems before I see him at that time. (Carrier Exh. D).

2. The EOB

As a basis for the denial in the Explanation of Benefits (EOB) dated May 11, 2002, Carrier listed codes N, TG, F, and JM. The EOB contained the following explanation in the "Rationale" section:

> TG Documentation does not support the service billed. Carriers may not reimburse the service at another billing codes' value per Rule 133.301(b). A revised CPT code or documentation to support the service billed may be submitted.
>
> JM The Medical Fee Guideline states in the importance of proper coding "Accurate coding of services rendered is essential f[or] proper reimbursement," the services performed are not reimbursable as billed.
>
> YF Fee guidelines MAR reduction. (Pet. Exh.1).

C. Arguments

1. Petitioner

Petitioner claimed that Carrier used unauthorized or repealed codes in the EOB, implying that the denial was inappropriate for lack of sufficient explanation. In particular, Petitioner challenged the use of the T denial code, presenting the TWCC Advisory 2002-11, dated August 11, 2002, which directed carriers not to use the T code in EOBs any longer. (Pet. Exh. 1).

Petitioner further argued that his documentation justified the use of CPT 99214. In addition to presenting the office visit note, Petitioner testified that the March 21, 2002, office visit note reflected an examination of several systems (musculo-skeletal, vascular, lymphatic), an assessment of the wound site, and an evaluation of Claimant's ability to return to unrestricted work status. Petitioner stated that the visit took at least 25 minutes and involved moderately complex decision making, particularly regarding Claimant's work status. To evaluate the work status, Petitioner needed to compare Claimant's physical abilities with his job requirements. This comparison built on, but was not duplicative of, a prior evaluation that resulted in Claimant being released to restricted duty. In Petitioner's opinion, the office visit documentation justified billing under CPT 99214 for an established patient office visit.

Petitioner also stated that it is routine for orthopedic surgeons to have regular bi-monthly office visits with patients after this type of ankle surgery until the fracture heals completely, which can take up to two years. Although Claimant was eight months post-surgery in March 2002, his need
for periodic evaluations justified the office visits, according to Petitioner. Finally, Petitioner pointed out that Carrier paid previous and subsequent billings under CPT Code 99214 based on the same type of documentation.

2. Carrier's Argument

Carrier argued that not only was CPT 99214 not the proper code for the nature of the service, but also that the office visits that occurred more than three months post-operatively constituted excessive care. Carrier also argued that the level of reimbursement paid Petitioner for other office visits was not determinative in this matter.

Carrier's expert witness, orthopedist Nick Tsourmas, testified that Petitioner's office notes reflected Claimant's fracture was healing without complications, so that the March 21, 2002, office visit was simply unnecessary, excessive care. According to Dr. Tsourmas, absent some complicating factor, the standard of care did not require monthly or bi-monthly evaluations more than ninety days post-operatively.

Although he believed that Petitioner provided Claimant with exemplary care, he criticized Petitioner for continuing to have regular office visits and for ordering x-rays for too long into the post-operative period. Dr. Tsourmas also found the office visit note failed to adequately document a decision of moderate complexity with regard to the work status evaluation.

Dr. Tsourmas also did not think the March 21st office visit note documented any medical decision making of moderate complexity or a detailed examination or history. He noted that the wording of the note differed very little from those in all the previous office visit notes to the point that most of the note appeared to be "boilerplate." If Petitioner's examination consisted of simply asking for updates or changes since the last examination, then it did not meet the criteria of CPT Code 99214, in Dr. Tsourmas's opinion. In that circumstance, a nurse should collect the updated information and the length of the office visit with the physician would not be expected to exceed 15 minutes. Dr. Tsourmas felt most post-operative office visits for patients who were doing well, such as Claimant, would be billed more appropriately under CPT Code 99213 with a lower reimbursement rate.

D. Legal Standards

Petitioner had the burden of proof in this matter. 28 TEX. ADMIN. CODE (TAC) §§ 148.21(h) and (i); 1 TAC §155.41. Pursuant to the Texas Workers' Compensation Act (Act), an employee who has sustained a compensable injury is entitled to all health care reasonably required by

the nature of the injury as and when needed. The employee is specifically entitled to health care that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment. TEX. LAB. CODE ANN. §408.021(a). Health care includes all reasonable and necessary medical services including a medical appliance or supply. TEX. LAB. CODE ANN. § 401.011(19)(A). A medical benefit is a payment for health care reasonably required by the nature of the compensable injury. TEX. LAB. CODE ANN. § 401.011(31).

E. Analysis

The scope of this appeal is limited to the issue of whether Petitioner billed the March 21, 2002, office visit correctly under CPT Code 99214. To be entitled to reimbursement under that code, Petitioner had to provide sufficient evidence to prove he engaged in two of the following actions: performed a detailed examination; took a detailed history; or made a medical decision of moderate complexity and the visit lasted at least twenty-five minutes.

Whether or not Petitioner was generally providing excessive care to Claimant, the evidence established that on March 21, 2002, Petitioner had a legitimate reason to examine and evaluate Claimant B to determine whether Claimant was ready to be released to work without restrictions. While the office note was rather terse, stating only that the "risks and complications" of unrestricted work status had been discussed, Petitioner's testimony added sufficient detail to establish that the office visit that day included a detailed evaluation and medical decision of moderate difficultly.

Petitioner explained that not only did he have to obtain an updated medical status, he had to examine several systems of the body and to evaluate whether Claimant could meet the demands of his unrestricted job duties. That evaluation involved a determination of how Claimant was handling tasks allowed on restricted duty, what additional duties Claimant would engage in if released to full duty, and what the medical implications of full duty work status would be for Claimant. Even granting Dr. Tsourmas was correct in describing the rote nature of the office visit note, Petitioner's description of the tasks involved supported his claim that the visit took at least twenty five minutes.

Carrier's argument implied that the return to work evaluation was covered by a separate code and thus did not support the use of CPT Code 99214. That argument was misguided. The CPT code for completing a release-to-work form covers just that B completion of the form. The underlying evaluation is properly billed in the office visit. Because Petitioner prevailed, his argument about improper EOB codes need not be addressed.

Petitioner met his burden to show that he is entitled to compensation from Carrier for $71 for Claimant's office visit billed under CPT Code 99214 on March 21, 2002.

III. FINDINGS OF FACT

1. In July 2001, orthopedic surgeon Donald Malone, M.D., operated on Claimant's ankle which had been broken in an accident compensable under the Texas Workers' Compensation Act (Act).

2. At the time of Claimant's compensable injury, Texas Mutual Insurance Company (Carrier) was the workers' compensation insurer for Claimant's employer.

3. Petitioner billed under CPT Code 99214 for an office visit with Claimant on March 21, 2002.

4. Carrier denied Petitioner's claim for the March 21, 2002, office visit.

5. The Texas Workers' Compensation Commission's Medical Review Division (MRD) upheld Carrier's denial based on insufficient documentation.

6. Petitioner appealed the MRD decision.

7. Pursuant to notice of hearing sent by Commission staff, all parties appeared at the hearing in this matter held April 22, 2002.

8. The notice of hearing contained the date, time, and location of the hearing; references to the applicable statutes and rules; and a short, plain statement of the disputed matter.

9. CPT Code 99214 requires face-to-face physician-patient interaction lasting at least 25 minutes with two of the following components: a detailed history; a detailed examination; or medical decision making of moderate complexity.

10. During the March 21, 2002, office visit, Petitioner examined several systems of the body, examined the wound site, gathered detailed information about Claimant's ability to perform the restricted duty job tasks, evaluated the job requirements for full duty status, discussed the medical implications of working on full duty status, and determined that Claimant's physical condition allowed him to return to unrestricted work.

11. The March 21, 2002, office visit lasted at least 25 minutes.

12. The March 21, 2002, office visit involved medical decision making of moderate complexity.

IV. CONCLUSIONS OF LAW

1 The Texas Workers' Compensation Commission (Commission) has jurisdiction related to this matter pursuant to the Texas Workers' Compensation Act (Act), TEX. LABOR CODE ANN. § 413.031.

2 The State Office of Administrative Hearings has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order, pursuant to § 413.031(d) of the Act and TEX. GOV'T CODE ANN. ch. 2003.

3 The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T CODE ANN. ch. 2001 and the Commission's rules, 28 TEX. ADMIN. CODE (TAC) § 133.305(g).

4 Adequate and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. §§2001.051 and 2001.052.

5 Petitioner has the burden of proof in this proceeding. 28 TAC §§ 148.21(h) and (i); 1 TAC § 155.41.

6 Pursuant to the Act, an employee who has sustained a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment. TEX. LAB. CODE ANN. § 408.021(a).

7 Health care includes all reasonable and necessary medical services, including a medical appliance or supply. TEX. LAB. CODE ANN. § 401.011(19)(A). A medical benefit is a payment for health care reasonably required by the nature of the compensable injury. TEX. LAB. CODE ANN. § 401.011(31).

8 Petitioner correctly billed for the March 21, 2002, office visit with Claimant under CPT Code 99214.

9 Petitioner is entitled to reimbursement from Carrier for the March 21, 2002, office visit with Claimant at the Commission's maximum allowable reimbursement rate for CPT Code 99214.

ORDER

IT IS ORDERED that Texas Mutual Insurance Company reimburse Donald Malone, M.D., for the March 21, 2002, office visit with Claimant at the Commission's maximum allowable rate for CPT code 99214.

SIGNED this 20th day of May 2003.

ANN LANDEROS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS