Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Edwin E. Johnstone MD

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-12-3690-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 28, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…I obtained a request of approval letter for and intake interview of this patient."

Amount in Dispute: $1,625.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…Coding did not match the documentation. ...Telephonic case management has a listed code. …The documentation is absent both a comprehensive history and exam. …The documentation is absent both a detailed history and exam. …Because it appears to be related to E/M billing within the previous seven days, there is no separate reimbursement. For these reasons no payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 11, 2012	99205	$500.00	$374.79
April 11, 2012	99354	$250.00	
April 25, 2012	99215	$250.00	
April 25 2012	99354	$125.00	
May 2, 2012	99214	$150.00	
April 11, 2012	99801	$500.00	
April 11, 2012	99354	$250.00	
April 24, 2012	90899	$100.00	
May 7, 2012	99443	$125.00	

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. Former 28 Texas Administrative Code §133.307, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, sets out the procedures for resolving medical fee disputes filed prior to June 1, 2012
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for E/M services

The services in dispute were reduced/denied by the respondent with the following reason codes:

- W1 – Workers Compensation State Fee Schedule Adjustment
- 714 – Accurate coding is essential for reimbursement. CPT/HCPCS Billed incorrectly. Services are not reimbursable as billed
- 892 – Denied in accordance with DWC Rules and/or medical fee guideline including current CPT code Descriptions/instructions
- 150 – Payer deems the information submitted does not support the level of service
- 16 – Claim/service lacks information which is needed for adjudication
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- 225 – The submitted documentation does not support the service being billed
- 890 – Denied per AMA CPT code description for level of service and/or nature of presenting problems
- 18 – Duplicate claim/service
- 284 – No allowance was recommended as this procedure has a Medicare status of "B" (Bundled)

Issues

1. Did the requestor meet the requirements of 28 Texas Administrative Code §134.203?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, "for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…" Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient. Date of service 04/11/2012. The American Medical Association (AMA) CPT code description for 99205 is:

   > 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 high 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, **60** minutes are spent face-to-face with the patient and/or family.

   The 1997 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare policy. It describes the documentation requirements for the service in dispute. Page 77 -78 of Evaluation and Management Services Guide specifically addresses elements of Psychiatric Examination. Review of the documentation finds the following:

   - Documentation of the Comprehensive History
     - History of Present Illness (HPI) consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions. Documentation found listed three chronic conditions, thus meeting this component.
     - Review of Systems (ROS) inquires about the system (s) directly related to the problem(s) plus additional body systems. At least ten organ systems must be reviewed. Documentation found listed xx systems, this component was met.
     - Past Family, and/or Social History (PFSH) requires a review of two or all history areas, at least one specific item from each history areas to be documented. The documentation found listed three areas. This component was met.
   - Documentation of a Comprehensive Examination:

     Constitutional
     - Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff). This component was not met.
     - General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming). This component was met.

Musculoskeletal

- Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements. This component was not met.
- Examination of gait and station. This component was not met

Psychiatric

- Description of speech including: rate; volume; articulation; coherence; and spontaneity with notation of abnormalities (eg. Preservation, paucity of language). The component was met
- Description of thought processes including: rate of thoughts; content of thoughts (eg, logical vs. illogical, tangential); abstract reasoning; and computation. The component was met
- Description of associations (eg, loose, tangential, circumstantial, intact). The component was met.
- Description of abnormal or psychotic thoughts including; hallucinations; delusions; preoccupation with violence; homicidal or suicidal ideation; and obsessions. This component was met.
- Description of the patient's judgment (eg, concerning everyday activities and social situations) and insight (eg, concerning psychiatric condition). This component was met

Complete mental status examination including

- Orientation to time, place and person. This component was met.
- Recent and remote memory. This component was met.
- Attention span and concentration. This component was met
- Language (eg, naming objects, repeating phrases) This component was met
- Fund of knowledge (eg, awareness of current events, past history, vocabulary) This component was met.
- Mood and affect (eg. Depression, anxiety, agitation, hypomania, lability) This component was met.

- Comprehensive – Perform all elements identified by a bullet; document every element in each box.

The division concludes that the documentation does not sufficiently support the level of service billed. The carrier's denial is supported.

Date of service, 04/11/2012. The American Medical Association (AMA) CPT code description for 99354 is: "Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour. Do not report any service less than **30** minutes". Review of the submitted documentation finds that the requestor documented, "I interviewed him in my office for over two hours." The documentation does not provide information to indicate the additional time spent was over 30 minutes. The carrier's denial is supported.

Date of service 04/25/12. The American Medical Association (AMA) CPT code description for 99215 is: "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 comprehensive history; A comprehensive examination; Medical decision making of high 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, **40** minutes are spent face-to-face with the patient and/or family". Review of the submitted documentation finds that the requestor had some contact with a physician from an E/R on 4/24/2012 and a "face-to-face" encounter. The documentation does show current activity, medications, results of visit with pain doctor's associate and change of medications. The record goes on to state, "I inspected his scarred skin…" The carrier's denial is not supported. Therefore the disputed service will be paid per applicable fee guidelines. (2012 DWC Conversion Factor / Medicare Conversion Factor**)** x Participating Amount = TX Fee MAR or 54.85/34.0376 x $133.41 = $215.02

Date of service 04/25/12. The American Medical Association (AMA) CPT code description for 99354 is: Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour. Review of the submitted documentation finds notes of time that total 49 minutes Nine minutes being over the 40 minutes described by code. Per further code instructions, "Do not report any service less than **30** minutes." The carrier's denial is supported.

Date of service 05/02/2012. The American Medical Association (AMA) CPT code description for 99214 is: 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. Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient. Submitted medical records supports consideration of past history of patient's condition and current history including medication and sleep patterns. A detailed exam is supported by descriptions of psychiatric symptoms. The carrier's denial is not supported. Therefore the disputed service will be paid per applicable fee guidelines. (2012 DWC Conversion Factor / Medicare Conversion Factor) x Participating Amount = TX Fee Mar or 54.85/34.0376 x 99.13 = $159.77.

Date of service 04/11/2012. The American Medical Association (AMA) CPT code description for 99001 on EOB, claim is not support by submitted document. The carrier's denial is supported.

Date of service 04/24/2012. The American Medical Association (AMA) CPT code description for 90899 is: Unlisted psychiatric service or procedure Psychiatric Services without Patient Face-to-Face Contact. Review of the submitted documentation finds that the performed an extended phone call prior to patient being admitted taken to Emergency Room. However, the use of this code (miscellaneous code) is not supported by documentation. The carrier's denial is supported.

Date of service 05/07/2012. The American Medical Association (AMA) CPT code description for 99443 is: Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion. Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient. Review of the medical record shows 37 minutes in conversation with care giver however, no documentation found to support the call was not related to office visit of May 2, 2012. The Carrier's denial is supported.

2. For the reasons stated above, the services in dispute supported by documentation are eligible for payment pursuant to 28 TAC §134.203 (c) as follows: Date of service 4/25/2012, Code 99215, allowed amount, $215.02 and Date of service 5/02/2012, Code 99214, allowed amount, $159.77 for a total allowed amount ($215.02 + $159.77) = $374.79.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $374.79.

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 $374.79 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 7, 2014 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.