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
Elite Healthcare Fort Worth

Respondent Name
Indemnity Insurance Company of North America

MFDR Tracking Number
M4-16-3680-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
August 12, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Treating provider has attached dictation for this patient's office visit. Dr. Lopez has outlined key components regarding this visit with the patient."

Amount in Dispute: $260.74

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The documentation provided for this date of service does not show Requestor performed **all** three components as required. The report shows a history and a comprehensive examination were completed. However, the history does not appear to be comprehensive, and there was no medical decision making of moderate complexity. The amount and/or complexity of the data reviewed was minimal, the risk of significant complications/morbidity was low. The medical decision was straightforward, not complex.

In conclusion, no monies should be awarded to Requestor for CPT code 99204 as the documentation does not support the level of service."

Response Submitted by: Downs-Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 11, 2016	Evaluation & Management, new patient (99204)	$260.74	$0.00

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 sets out the procedures for determining the fee schedule for professional services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 150 – Payer deems the information submitted does not support this level of service.
   - V122 – The level of the E & M code submitted is not supported by documentation.
   - 18 – Duplicate claim/service.
   - U301 – This item was previously submitted and reviewed with a notification of decision issued to payor, provider (duplicate invoice).

Issues

Did the requestor support the level of service for CPT Code 99204 as required by 28 Texas Administrative Code §134.203?

Findings

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 a new patient.

The American Medical Association (AMA) CPT code description for 99204 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 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, 45 minutes are spent face-to-face with the patient and/or family [emphasis added].

The *1997 Documentation Guidelines for Evaluation & Management Services* is the applicable Medicare guideline to determine the documentation requirements for the service in dispute. Review of the documentation finds the following:

- Documentation of the Comprehensive History:
  - "An *extended* [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 four elements of the HPI, thus meeting this element.
  - "A *complete* [Review of Systems (ROS)] inquires about the system(s) directly related to the problem(s) identified in the HPI, *plus* all additional systems. [Guidelines require] at least ten organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented." Documentation found two systems reviewed. This element was not met.
  - "A *complete* [Past Family, and/or Social History (PFSH)] is a review of … all three of the PFSH history areas." The documentation finds that one history area was reviewed. This element was not met.

  The Guidelines state, "To qualify for a given type of history all three elements in the table must be met." A review of the submitted documentation indicates that only one element was met for a Comprehensive History, therefore this component of CPT Code 99204 was not supported.

- Documentation of a Comprehensive Examination:
    - A "*comprehensive* examination [for a single organ system] …should include performance of all elements [of the Musculoskeletal Examination table]… For the comprehensive level of examination [for the musculoskeletal system], all four elements identified by a bullet must be performed and documented for each of four anatomic areas." A review of the submitted records finds that the documentation does not meet the stated requirements. Within the musculoskeletal system, three elements identified by a bullet were performed for two anatomic areas. Two of the remaining eleven required bullets were documented. Therefore, this component of CPT Code 99204 was not met.
- Documentation of Decision Making of Moderate Complexity:
    - *Number of diagnoses or treatment options* – Review of the submitted documentation finds that a new problem to the examiner was presented with additional workup planned, meeting the documentation requirements of Extensive complexity. Therefore, this element was exceeded.
    - *Amount and/or complexity of data to be reviewed* – Review of the documentation finds that the requestor ordered a test in the medicine section of the CPT manual. "Moderate complexity in decision-making requires moderate complexity of data." The documentation supports that this element met the criteria for low complexity of data reviewed. Therefore, this element was not met.
    - *Risk of complications and/or morbidity or mortality* – Review of the submitted documentation finds that presenting problems include two or more self-limited or minor problems; physiologic tests for function were ordered; and, pain management and physical therapy were ordered. "The highest level of risk in any one category…determines the overall risk." The documentation supports that this element met the criteria for low risk. Therefore, this element was not met.

  "To qualify for a given type of decision making, **two of the three elements … must be either met or exceeded**." A review of the submitted documentation supports that one element was supported. For this reason, this component of CPT Code 99204 was not met.

The division finds that the requestor failed to support the level of service for procedure code 99204 required by 28 Texas Administrative Code §134.203. No further reimbursement is recommended.

Conclusion

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

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	October 28, 2016
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.