TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Center for Pain Relief

Respondent Name
Valley Forge Insurance Co.

MFDR Tracking Number
M4-24-1871-01

Carrier's Austin Representative
Box Number 57

DWC Date Received
April 22, 2024

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
November 8, 2023	99214	$178.13	$178.13
	Total	$178.13	$178.13

Requestor's Position

"We sent a reconsideration to the carrier noting the office visit was 30 minutes and the description for billing Code 99214 states, '... when using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.' We have billed the correct code for our service to this patient."

Amount in Dispute: $178.13

Respondent's Position

"... Bill Review Services maintains that no additional allowable is due as the documentation submitted by the provider does not support a Level IV CPT 99214 visit as per the AMA CPT guidelines... At this time the provider has not submitted additional treatment notes to support the use of CPT 99214... reimbursement is not recommended..."

Response Submitted by: LAW OFFICES OF BRIAN J. JUDIS

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the fee guideline for professional medical services.
3. 28 TAC §133.210 sets out medical documentation requirements for reimbursement of medical services.

Denial Reasons

The insurance carrier denied the payment for the disputed service with the following claim adjustment codes:

- 16 – CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION.
- 309 -THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
- 589 -THE DOCUMENTATION RECEIVED DOES NOT SUPPORT THE LEVEL OF SERVICE BILLED. PLEASE ADJUST THE LEVEL OF SERVICE BILLED OR PROVIDE ADDITIONAL DOCUMENTATION TO SUPPORT THE SERVICE BILLED.
- P12 – WORKERS' COMPENSATION FEE SCHEDULE ADJUSTMENT.
- 5211 - NURSE AUDIT HAS RESULTED IN AN ADJUSTED REIMBURSEMENT.
- 193 - ORIGINAL PAYMENT DECSION IS BEING MAINTAINED. UPON REVIEW IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 1014 - THE ATTACHED BILLING HAS BEEN RE-EVALUATED AT THE REQUEST OF THE PROVIDER. BASED ON THIS RE-EVALUATION. WE FIND OUR ORIGINAL REVIEW TO BE CORRECT. THEREFORE, NO ADDITIONAL ALLOWANCE APPEARS TO BE WARRANTED.

Issues

1. What rules apply to the disputed services?
2. Is the insurance carrier's denial reason supported?
3. Is the requestor entitled to reimbursement for CPT Code 99214 rendered on November 8, 2023?

Findings

1. The dispute concerns an evaluation and management service billed under CPT code 99214.

   DWC finds that 28 TAC §133.210(c)(1) applies to the documentation requirements of CPT code 99214. 28 TAC §133.210 (c)(1) sets out the medical documentation requirements, stating in pertinent part "In addition to the documentation requirements of subsection (b) of this section, medical bills for the following services shall include the following supporting documentation: the two highest Evaluation and Management office visit codes for new and established patients: office visit notes/report satisfying the American Medical Association requirements for use of those CPT codes…"

   As CPT code 99214 is one of the two highest evaluation and management codes for established patient visits, DWC finds that (TAC) §133.210(c)(1) required the requestor to submit supporting documentation to satisfy American Medical Association requirements.

   DWC finds that 28 TAC §134.203 (b)(1) applies to the billing and reimbursement of disputed service CPT code 99214. 28 TAC §134.203(b)(1) states, "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; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

2. The requestor is seeking reimbursement in the amount of $178.13 for CPT Code 99214 rendered on November 8, 2023. The insurance carrier denied the service asserting that the documentation does not support the level of CPT code 99214.

   - CPT Code 99214 is defined as, "Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making (MDM). When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter."
   - The American Medical Association (AMA) CPT Code and Guideline Changes, effective January 1, 2021, can be found at: https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf and states in pertinent part "Beginning with CPT 2021, except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services…"
   - In summary, CPT 99214 documentation must contain two out of three of the following elements: 1) moderate level of number and complexity of problems addressed 2) moderate level of amount and/or complexity of data to be reviewed and analyzed 3) moderate risk of morbidity/mortality of patient management OR must document 30-39 minutes of total time spent on the date of patient encounter.
   - An interactive E&M scoresheet tool is available at: www.novitas-solutions.com/webcenter/portal/MedicareJL/EMScoreSheet
   - A review of the submitted medical record finds that 30 minutes of time spent on the disputed date of encounter was documented. The medical record submitted also

documents 1) a moderate level of complexity of problems addressed and 2) a moderate risk of complications of patient management. For these reasons, DWC finds that the medical documentation submitted did meet AMA criteria for reimbursement of CPT code 99214 and therefore, the insurance carrier's denial reason is not supported.

DWC finds that the insurance carrier's denial reason is not supported.

3. Because the insurance carrier's denial reason is not supported, DWC finds that the requestor is entitled to reimbursement.

   DWC finds that 28 TAC §134.203 applies to the billing and reimbursement of the disputed service CPT code 99214. 28 TAC §134.203(b)(1) states, "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; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   28 TAC §134.203(c) continues, stating in pertinent part, "To determine the maximum allowable reimbursement (MAR) for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors and shall be effective January 1st of the new calendar year."

   To determine the MAR the following formula is used:
   (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = MAR.

   - The disputed date of service is November 8, 2023.
   - The disputed service was rendered in zip code 75039, locality 11, Dallas; carrier 4412.
   - The Medicare participating amount for CPT code 99214 in 2023 at this locality is $129.16.
   - The 2023 DWC Conversion Factor is 64.83
   - The 2023 Medicare Conversion Factor is 33.8872.
   - Using the above formula, DWC finds the MAR is $247.10.
   - The respondent paid $0.00.
   - The requestor is seeking $178.13 for CPT code 99214 rendered on the disputed date of service. Therefore, this amount is the recommended reimbursement amount.
   - Reimbursement in the amount of $178.13 is recommended for disputed CPT code 99214 rendered on November 8, 2023.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requestor has established that reimbursement is due in the amount of $178.13.

ORDER

Under Texas Labor Code §§413.031, the DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that Valley Forge Insurance Co., must remit to Center for Pain Relief $178.13 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		May 21, 2024
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.