

STATE OF MICHIGAN
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES
Before the Director of Insurance and Financial Services

In the matter of:

██████████
Petitioner

v

Physicians Health Plan
Respondent

File No. 145554-001

Issued and entered
this 26th day of January 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On December 29, 2014, ██████████ (Petitioner) filed a request with the Director of Insurance and Financial Services for an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The Petitioner receives health care benefits as a member of Physicians Health Plan (PHP), a health maintenance organization. The Petitioner's health benefits are defined in the *PHP HMO Plus* certificate of coverage. The Director notified PHP of the external review request and asked for the information used to make its final adverse determination. PHP furnished the information on January 2, 2015. On January 6, 2015, after a preliminary review of the material submitted, the Director accepted the request for review. PHP provided additional information on January 19, 2015.

This case involves medical issues. Therefore, the Director assigned it to an independent review organization which submitted its analysis and recommendation on January 21, 2015.

II. FACTUAL BACKGROUND

The Petitioner has a history of temporomandibular joint dysfunction. She has been fitted with an orthotic device to treat her condition. On January 10, 2014, she visited ██████████, to report complaints of increased noise sensitivity, ear pain and fullness in her ears. During the visit, ██████████ determined that the Petitioner's orthotic device was not positioned properly. He made the necessary adjustments to the device. The Petitioner paid \$182.00 for the visit. The Petitioner paid a \$10.00 copayment and submitted a reimbursement

request to PHP for \$172.00. The reimbursement request was based [REDACTED] documentation of his treatment as procedure code 99214 (“Office or other outpatient visit for the evaluation and management of an established patient...Usually, the presenting problems are of moderate to high severity.”).¹ PHP denied reimbursement, ruling that the medical records did not support reimbursement for procedure code 99214.

The Petitioner appealed the denial through PHP’s internal grievance process. During that process, Petitioner resubmitted a reimbursement request using a different procedure code, 99213 (“Office or other outpatient visit for the evaluation and management of an established patient...Usually, the presenting problems are of low to moderate severity.”). At the conclusion of the internal grievance process, on December 22, 2014, PHP issued a final adverse determination affirming its decision to deny coverage for [REDACTED] services under both codes.

The Petitioner now seeks a review of that adverse determination from the Director.

III. ISSUES

Did the treatment the Petitioner received on January 10, 2014 meet the coverage requirements of the procedure codes selected by the Petitioner’s dentist?

Did the dentist provide sufficient documentation to support the claim?

IV. ANALYSIS

Respondent’s Argument

In its final adverse determination, PHP wrote:

Your request was denied because your medical record does not support reimbursement for procedure code 99214.

In addition, we reviewed the medical records submitted to support reimbursement for the procedure code 99213. Our decision is to also deny reimbursement for procedure code 99213 because this code is not supported by the medical record.

PHP follows the Centers for Medicare & Medicaid Services (CMS) guidelines for the required documentation from the patient's record that must be present to

1. Medical procedures performed by physicians and other health care providers are classified using numeric codes. This system was established by the American Medical Association which publishes *Current Procedural Terminology*, a manual used in the health insurance industry for processing insurance claims. The codes, commonly referred to as “CPT codes,” are typically five digit numbers that identify a particular medical procedure.

support billing CPT code 99214 or 99213. Both procedure codes state that the provider must document two of three components outlined in the enclosed Fact Sheets. The medical records submitted with the claims were not thorough or detailed enough to support that 2 of 3 elements for either code were met. We also included information with this letter that outlines proper documentation, signature requirements and more detailed guidelines for billing the various evaluation and management codes.

Petitioner's Argument

The Petitioner argues that [REDACTED] treatment was sufficiently complex to support a claim under either procedure code. She also asserts that [REDACTED] did provide PHP with the documentation necessary to support her claim. In her request for an external review, the Petitioner wrote:

Seeking reimbursement for a claim I have already paid in amount of \$182.00. Been denied for 99214 code thru general grievance & then PHP denied resubmission of 99213 code without even reviewing claim form & additional documentation from Drs. office regarding time spent w/patient. In hearing was told they could only review for code submitted of 99214 however 12/22 letter denies claim of both codes.

Director's Review

Procedure codes 99213 and 99214 are defined in *Current Procedural Terminology*, page 12:

99213 Office or other outpatient visit for the evaluation and management of an established patient which requires at least 2 of these 3 key components:

- **An expanded problem focused history;**
- **An expanded problem focused examination**
- **Medical decision making of low complexity**

Counseling and coordination of care with other providers 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 low to moderate severity.

Physicians typically spend 15 minutes face-to-face with the patient and/or family.

99214 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 providers 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.

Physicians typically spend 25 minutes face-to-face with the patient and/or family.

To determine if the Petitioner's claim, as documented by her dentist, met the requirements of procedure codes 99214 or 99213, the Director asked an independent medical review organization (IRO) to review the case as required by section 11(6) of the Patient's Right to Independent Review Act, MCL 550.1911(6).

The IRO reviewer is a dentist who has been in active practice for more than 10 years. The IRO reviewer's report included the following analysis and recommendation:

The member presented with a history of temporomandibular joint dysfunction, for which she had been treated in the past with an orthotic bite appliance with an apparent decrease in symptoms. Progress notes state that the member had an appointment on 1/10/14 for the re-evaluation of her chief complaint and the orthotic appliance....[T]he progress notes provided for review document a minimal examination of the chief complaint at that visit with an adjustment to the orthotic device....[A]n addendum to the progress note states that the examination and adjustment were at the request of the treating osteopathic physician and specify a total treatment time of 18 minutes, with the primary procedure being performed that day of a resurfacing and equilibration of the appliance. The resurfacing was stated to involve addition of material to the appliance....[A]n orthotic appliance of this type is typically an acrylic composition....[A]ddition of acrylic to this device to treat what was documented as a closed bite, with subsequent equilibration of the device to assure even contact to either another appliance or the member's dentition would typically be expected to be moderately time consuming....[A]s such, the principal procedure performed at that office visit would be shown to be the adjustment of the orthotic device with only minimal time spent on a limited examination and history of present illness.

CPT code 99213 specifies an expanded problem-focused history and/or examination. CPT code 99214 requires a detailed examination and/or history. Both codes include a third component of medical decision making of either low or moderate complexity....[W]ith no documentation in the progress notes of anything other than a limited examination and history taking shown to be a minimal update to the previous history, the performance of CPT code 99213 or 99214 was not supported in the information provided for review as two of the three key criteria for billing these codes were not documented.

Pursuant to the information set forth above and available documentation...the medical documentation provided does not support the billing of CPT codes 99214 and 99213 on 1/10/14....

The Director is not required to accept the IRO's recommendation. *Ross v Blue Care Network of Michigan, 480 Mich 153 (2008)*. However, the IRO's recommendation is afforded deference by the Director. In a decision to uphold or reverse an adverse determination, the Director must cite "the principal reason or reasons why the [Director] did not follow the assigned independent review organization's recommendation." MCL 550.1911(16)(b). The IRO's analysis is based on extensive experience, expertise and professional judgment. Furthermore, it is not contrary to any provision of the Petitioner's certificate of coverage. MCL 550.1911(15). The Director can discern no reason why the IRO's recommendation should be rejected in the present case.

The Director accepts the IRO reviewer's conclusion that the documentation available does not support the billing of CPT codes 99213 or 99214 for the Petitioner's treatment on January 10, 2014. The Director makes no finding as to whether some other alternative CPT code would more accurately describe the care the Petitioner received.

V. ORDER

The Director upholds PHP's December 22, 2014 final adverse determination. PHP is not required to provide reimbursement under CPT codes 99213 or 99214 for the services the Petitioner received on January 10, 2014.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this order may seek judicial review no later than 60 days from the date of this order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Department of Insurance and Financial Services, Office of General Counsel, Post Office Box 30220, Lansing, MI 48909-7720.

Annette E. Flood
Director

For the Director:



Randall S. Gregg
Special Deputy Director