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
Mark H. Henry, MD

Respondent Name
Service Lloyds Insurance Company

MFDR Tracking Number
M4-15-1544-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
January 26, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The healthcare provider's position in this claim is that the services have been underpaid. We find that none of the services billed on the claim were paid at 100% of the statutory fee as required by law per Texas Administrative Code Title 28 Part 2 Chapter 134 Subchapter C Rule 134.202. The attached medical records adequately support each of the services provided and is sufficient to warrant payment as set forth by the aforementioned section of the Texas Administrative Code. Additionally, the attached explanation of benefits (EOB) from the carrier clearly shows the underpayment of services provided. Please review the paid amounts as they pertain to the MAR (maximum allowable Reimbursement) for the services submitted."

Amount in Dispute: $343.07

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "For the service in dispute, reimbursement was denied as no documentation was submitted to support a separate examination took place. Please note that the surgery performed the same day was reimbursed as documentation including the operative report was submitted with the billing. Also, modifier -57 was included which means a decision was made regarding surgery during the visit. However, without a copy of the documentation indicating a separate visit was held with a surgery decision being made, no reimbursement is allowed.

Rule 133.210 requires medical providers to submit the required documentation in order to process a bill. The provider in this matter failed to submit the emergency room record. Further, Rule 133.20(h) requires health care providers to submit any additional documentation within 15 days. Both the initial Explanation of Benefits and the reconsideration Explanation of Benefits note that additional documentation is need for CPT Code 99285 since separate reimbursement had been requested.

As the requested documentation was not supplied, additional reimbursement is not permitted. Reimbursement is limited to the allowed amount for CPT 11012. According to Medicare payment policies an E/M service on the same day or on the day before a procedure with a 90-day global surgical period is covered if modifier -57 is used to indicate that the service resulted in the decision to perform the procedure. The Requestor billed CPT Code 11012 which has a 90-day global surgical period. The Requestor did note the -57 with CPT Code 99285. However, no documentation was submitted to show this was a separate examination with a decision for surgery being made.

Wherefore, Respondent seeks a finding that Requestor is denied any additional reimbursement for the services performed on the date of service. Respondent respectfully requests consideration of its position stated herein and seeks continued denial of any reimbursement."

Response Submitted by: White/Espey, PLLC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 9, 2014	Evaluation & Management, Emergency Department (99285)	$343.07	$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 §133.210 sets out the requirements for medical records for medical billing.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for billing and reimbursing professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16 – Not all info needed for adjudication was supplied
   - 182 – Reviewed as no charge
   - 150 – Payment adjusted/unsupported service level
   - Note: submit a copy of the emergency room notes for review of this level of service.

Issues

1. What is the correct rule to review the disputed services?
2. Did the requestor support the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.203 (a) states, "(2) This section applies to professional medical services provided on or after March 1, 2008. (3) For professional services provided between August 1, 2003 and March 1, 2008, §134.202 of this title (relating to Medical Fee Guideline) applies." This dispute involves professional services provided on May 9, 2014. Therefore, 28 Texas Administrative Code §134.203 is the correct fee schedule to apply to this dispute.
2. The insurance carrier denied payment for the disputed services stating, "Not All Info Needed for Adjudication was Supplied," and "Payment adjusted/unsupported service level." 28 Texas Administrative Code §133.210 states, in relevant part, "(b) When submitting a medical bill for reimbursement, the health care provider shall provide required documentation in legible form, unless the required documentation was previously provided to the insurance carrier or its agents. (c) In addition to the documentation requirements of subsection (b) of this section, medical bills for the following services shall include the following supporting documentation: (1) 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**" [emphasis added].

   The American Medical Association defines CPT Code 99285 as "Emergency department visit for the evaluation and management of a patient, which **requires these 3 key components** within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: **A comprehensive history; A comprehensive examination; and 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 high severity and pose an immediate significant threat to life or physiologic function" [emphasis added].

   Review of the submitted documentation does not support that the requestor performed a comprehensive history or a comprehensive examination. Therefore, the requestor did not support the disputed services.
3. Because the disputed services are not supported, 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	April 2, 2015
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.