



# 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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

MARK H. HENRY, MD

**Respondent Name**

AMERICAN ZURICH INSURANCE CO

**MFDR Tracking Number**

M4-15-2679-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

APRIL 21, 2015

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "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."

**Amount in Dispute:** \$343.07

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Our bill audit company has determined no further payment is due...CPT code 99285 is not recommended for reimbursement. The provider does not include a separately identifiable E&M service in the documentation."

**Response Submitted by:** Gallagher Bassett

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 3, 2014	CPT Code 99285-57 Emergency Department Visit	\$343.07	\$0.00

#### FINDINGS AND DECISION

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

**Background**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 11(112)-Service not furnished directly to the patient and/or not documented.
  - W3-Request for reconsideration.

- P12-Workers compensation jurisdictional fee schedule adjustment.

**Issues**

Does the documentation support billing CPT code 99285? Is the requestor entitled to additional reimbursement?

**Findings**

28 Texas Administrative Code §134.203(a)(5) states “Medicare payment policies” when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.”

The respondent denied reimbursement for CPT code 99285-57 based upon reason code “11(112).”

CPT code 99285 is defined 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.”

A review of the submitted documentation does not include an emergency department visit report; therefore, the requestor did not support billing CPT code 99285. As a result, reimbursement is not 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**

_____	_____	06/25/2015
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, 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 MFDR 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.**