TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Hand and Wrist Center of Houston

Respondent Name
Bitco General Insurance Corporation

MFDR Tracking Number
M4-16-0491-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 23, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The emergency room consult (procedure code 99285) was needed to determine whether or not the surgery performed was needed."

Amount in Dispute: $343.07

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "To date, including the materials provided by Dr. Henry in his medical dispute resolution request, Bitco has not received documentation to support a high-level emergency room evaluation and management visit in addition to surgical procedures performed on the same day."

Response Submitted by: Burns Anderson Jury & Brenner, L.L.P.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 21, 2014	Evaluation & Management, emergency visit (99285)	$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

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 documenting medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Service lacks information needed or has billing error(s)

Issues

Is the insurance carrier's reason for denial of payment supported?

Findings

The insurance carrier denied disputed services with claim adjustment reason code 16 – "Svc lacks info needed or has billing error(s)."

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** [emphasis added]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** [emphasis added]. 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.

Review of the submitted documentation does not support CPT code 99285-25 in accordance with 28 Texas Administrative Code §133.210. The insurance carrier's denial is 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	November 13, 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.