



# 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**

ORTHOTEXAS PHYSICIANS AND SURGEON  
ADAM CRAWFORD, MD

**Respondent Name**

SERVICE LLOYDS INSURANCE CO

**MFDR Tracking Number**

M4-16-0689-01

**Carrier's Austin Representative**

Box Number 01

**MFDR Date Received**

NOVEMBER 13, 2015

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "We are asking you to pay on this visit. We're requesting that you review the attached claims again and process accordingly."

**Amount in Dispute:** \$495.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "HCP has billed POS 21 (Inpatient Hospital); however, both the documentation provided by the requestor and the facility's bill (Exhibit B) clearly indicate the patient was not admitted as an inpatient. Services were documented as being provided in the ED (emergency department). There are separate codes for use by the physician when performing Evaluation and Management of a patient in the ED."

**Response Submitted By:** Corvel

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 1, 2015	CPT Code 99223-57 Initial Hospital Care	\$495.00	\$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**

- 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 out the reimbursement guidelines for professional services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

- B12-Svcs not documented in patient record.
- 57-Decision for Surgery
- W3-Appeal/Reconsideration.
- 193-Original payment decision maintained.

**Issues**

Does the documentation support billing code 99223? Is the requestor entitled to reimbursement?

**Findings**

1. 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.”

CPT code 99223 is defined as “Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: 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 problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.”

The respondent states, “HCP has billed POS 21 (Inpatient Hospital); however, both the documentation provided by the requestor and the facility’s bill (Exhibit B) clearly indicate the patient was not admitted as an inpatient. Services were documented as being provided in the ED (emergency department). There are separate codes for use by the physician when performing Evaluation and Management of a patient in the ED.”

A review of the submitted medical report does not support billing code 99223; therefore, reimbursement is not recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that 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**

		12/10/2015
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.**