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
MARK H. HENRY, MD

Respondent Name
SERVICE LLOYDS INSURANCE CO

MFDR Tracking Number
M4-19-4718-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
JULY 1, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We find that one of the charges on this claim has not been 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 in the aforementioned section of the Texas Administrative Code."

Amount in Dispute: $392.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We are upholding the prior review. 99285-57-The submitted document of pre-procedure orders does not support the billing of CPT code 99285-57 for emergency visit with decision for surgery. Therefore, we are unable to recommend any additional allowance."

Response Submitted By: Avidel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 2, 2018	CPT Code 99285 Emergency Room Visit	$392.28	$0.00
	CPT Code 26765 Professional Fee for Surgical Procedure on Finger	$0.00	$0.00
	CPT Code 11012 Professional Fee for Surgical Procedure on Finger	$0.00	$0.00
	CPT Code 11760 Professional Fee for Surgical Procedure on Finger	$0.00	$0.00
TOTAL		$392.28	$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 §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 220-The provider billed for a visit on the same day of surgery or, within the follow-up of a previously performed surgery.
   - 18-Exact duplicate claim/service.
   - 350-Bill has been identified as a request for reconsideration or appeal.
   - 756-Per rule 133.250 provider may not submit reconsideration after the carrier has taken final action. Seek MDR in accordance to rule 133.307.
   - W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

Is the requestor entitled to reimbursement for CPT code 99285 rendered on July 2, 2018?

Findings

1. The fee guidelines for disputed services are found in 28 Texas Administrative Code §134.203.
2. On the disputed date of service, the requestor billed CPT codes 99285, 26765, 11012 and 11760. Only code 99285 is in dispute.
3. 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."
4. CPT code 99285 is described 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."
5. The insurance carrier denied reimbursement for the emergency office visit , CPT code 99285, based upon reason codes "97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated, and 220-The provider billed for a visit on the same day of surgery or, within the follow-up of a previously performed surgery."
6. Per CCI edits, CPT code 99285 is not included in the allowance of any other service rendered on the disputed date of service; therefore, the respondent's denial of payment based upon reason codes "97" and "220" is not supported.

7. A review of the submitted medical records, does not support a comprehensive history; therefore, the documentation does 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 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

		7/17/2019
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.