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
UT Health Carthage

Respondent Name
Luba Casualty Insurance Co

MFDR Tracking Number
M4-21-0005-01

Carrier's Austin Representative
Box Number 53

MFDR Date Received
September 1, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Payor claims that Cpt code 99285 is not supported in the documentation. We sent a Clinical Appeal and the denial was maintained."

Amount in Dispute: $890.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The medical records provider submitted do not provide evidence of medical decision making of high complexity. The present problem was not of high severity, and did not pose an immediate significant threat to life or physiological function; therefore, this level of service was not established."

Response Submitted by: Hoffman Kelley Lopez LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 7, 2020	Outpatient Hospital Services	$890.36	$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 §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:
    - P12 – Workers' compensation jurisdictional fee schedule adjustment
    - 150 – Payer deems the information submitted does not support this level of service

- DDL – Documentation does not support the E/M level billed. Please resubmit with corrected coding/documentation for further review

Issues

Is the insurance carrier's denial supported?

Findings

The requestor is seeking additional reimbursement in the amount $890.36 for outpatient hospital services rendered on February 7, 2020. The insurance carrier reduced the disputed services as disputed service not supported by documentation.

28 TAC §134.403 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

The disputed service is 99285 which 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."

Review of the submitted "Provider Note", found "Minor Trauma," the history was expanded problem focused, the examination was also expanded problem focused and the level of decision making was low. Based on this review, the insurance carrier's denial is supported.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has not established payment is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

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Authorized Signature

______________________	______________________	September 25, 2020
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 Rule §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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.