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
THE WOODLANDS PAIN INSTITUTE

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-19-0282-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
SEPTEMBER 18, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "There is the claim form."

Amount in Dispute: $254.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requester billed $254.00 for code 99214. Texas Mutual paid $0.00 absent documentation the billing, which is required, for this code by Rule 133.210…The requestor submitted a request for reconsideration, along with the required documentation. After review, Texas Mutual concluded the documentation did not meet the CTP criteria for 99214…Now the requester submitted a request for medical fee reimbursement dispute resolution and lists code 99213 on the Table of Disputed Service. However, Texas Mutual has not reduced or denied payment of code 99213 because Texas Mutual has no record of receiving a bill for code 99213."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 9, 2017	CPT Code 99213 Office Visit	$254.00	$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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the health care providers billing procedures.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
4. 28 Texas Administrative Code §133.250 sets out the medical bill processing and audit by insurance carriers procedures.
5. Neither party to the dispute submitted any explanation of benefits, EOBs, for CPT code 99213 rendered on the disputed date of service.

Issues

Is CPT code 99213 rendered on November 9, 2017 eligible for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307?

Findings

According to the DWC-60, the requestor is seeking reimbursement for CPT code 99213 rendered on November 9, 2017.

Whether the requestor's medical fee dispute is eligible for review relies upon whether the requestor satisfied the relevant prerequisite requirements as follows:

- 28 Texas Administrative Code §133.20(f) states" Health care providers shall not resubmit medical bills to insurance carriers after the insurance carrier has taken final action on a complete medical bill and provided an explanation of benefits except in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills)."
- 28 Texas Administrative Code §133.20(g) states " Health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier."
- 28 Texas Administrative Code §133.240(a) states "An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation."
- 28 Texas Administrative Code §133.250(d) states "A written request for reconsideration shall: (1) reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill."
- 28 Texas Administrative Code §133.250(i) states "If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills)."
- 28 Texas Administrative Code §133.307(c)(2) requires requests for medical fee dispute resolution to submit:

  "(J) a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions);

  (K) a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB."

The division reviewed the submitted documentation and finds the following:

- The requestor is seeking medical dispute resolution for CPT code 99213.
- The respondent wrote, "Texas Mutual has not reduced or denied payment of code 99213 because Texas Mutual has no record of receiving a bill for code 99213."
- The requestor submitted a bill listing CPT code 99213 and G8427 to the division.
- The requestor did not submit any documentation to support CPT code 99213 was submitted to the respondent.
- The requestor did not submit any documentation to support CPT code 99213 was submitted to the respondent for reconsideration.
- The submitted explanation of benefits list CPT code 99214 not 99213.
- The requestor did not submit any explanation of benefits for CPT code 99213 rendered on November 9, 2017.
- The division concludes that CPT code 99213 rendered on November 9, 2017 is not eligible for review per 28 Texas Administrative Code §133.307 and §133.250.

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

		11/27/2018
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.