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
LAUREL MEDICAL ASSOCIATES, LLC

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-19-3912-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
APRIL 24, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Resubmitting the claim with supporting documentation for favorable review. Please reprocess your member's claim promptly to avoid future attempts to obtain status of this resubmission."

Amount in Dispute: $165.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual on 10/8/2018 received the bill from Laurel Medical Associates LLC…The provider indicates in the DWC60 packet that they tried to contact the adjuster on 9/8/18 to obtain mailing address for the carrier. Per documentation submitted in the DWC60 packet, the provider has Texas Mutual listed as the payer on 6/22/18. There is a 3 month gap the provider had to obtain additional carrier information…The rationale given by the requestor for the late bill is not consistent with the Rule above."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 14, 2018	CPT Code 99213	$165.00	$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, effective May 31, 2012, 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. Neither party submitted any explanation of benefits to support the denial of payment for the services in dispute.

Issues

Does the documentation support billing CPT code 99213? Is the requestor due reimbursement?

Findings

1. The requestor is seeking payment of $165.00 for an office visit rendered on June 14, 2018.

2. Because explanation of benefits were not submitted by either party to this dispute, the division will determine if reimbursement is due per the fee guideline.

3. The fee guidelines for disputed services are found in 28 Texas Administrative Code §134.203.

4. 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."

5. CPT code 99213 is described as "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and 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 low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family."

6. 28 Texas Administrative Code §133.307(c)(2)(M) requires the provider to submit "a copy of all applicable medical records related to the dates of service in dispute."

7. The requestor did not submit a medical report to support billing code 99213; 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

		5/22/2019
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.