



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
UMC PHYSICIANS

Respondent Name
UMC HEALTH SYSTEM

MFDR Tracking Number
M4-19-5300-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
AUGUST 22, 2019

REQUESTOR'S POSITION SUMMARY

"The services provided on 02/20/2019 were denied 'claim/service lacks information or has submission/billing error(s)'...Please process for payment."

Amount in Dispute: \$185.00

RESPONDENT'S POSITION SUMMARY

"we have escalated the bills in question for bill review audit and payment."

Response Submitted By: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 20, 2019	CPT Code 99203 Office Visit	\$185.00	\$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 (DWC).

Background

- 28 Texas Administrative Code §133.307, effective May 31, 2012, 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.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:

- 16-Claim/service lacks information or has submission/billing error(s).

Issues

Does the documentation support billing CPT code 99203? Is the requestor due reimbursement?

Findings

1. The requestor is seeking medical dispute resolution in the amount of \$185.00 for CPT code 99203 rendered on February 20, 2019.
2. The respondent denied reimbursement for CPT code 99203 based upon "16-Claim/service lacks information or has submission/billing error(s)."
3. The fee guidelines for disputed services are found in 28 Texas Administrative Code §134.203.
4. 28 TAC §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 99203 is described as "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity."

The DWC finds the requestor did not submit a report to support billing CPT code 99203; therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the DWC 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 DWC has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

Date

10/16/2019

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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **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.