



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

ELITE HEALTHCARE GARLAND

Respondent Name

ARCH INDEMNITY INSURANCE CO

MFDR Tracking Number

M4-20-1375-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

FEBRUARY 3, 2020

REQUESTOR'S POSITION SUMMARY

"The attached date of service was denied in full. These services were denied based on 'extent of injury'. This is INCORRECT."

Disputed Amount: \$124.31

RESPONDENT'S POSITION SUMMARY

"Per fee schedule review, the bill priced correctly."

Response Submitted By: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 6, 2019	CPT Code 99213	\$124.31	\$124.31

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 (TAC), 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:
 - 00086, 18-Exact duplicate claim/service.
 - W3-Request for reconsideration.

- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor due reimbursement for CPT code 99213 rendered on August 6, 2019?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of \$124.31 for CPT code 99213 rendered on August 6, 2019.
2. The respondent denied reimbursement for CPT code 99213 based upon "Exact duplicate claim/service."
3. On the disputed date of service, the requestor billed CPT codes 99213. The DWC finds the respondent did not support basis of denial that code 99213 was a duplicate to another service.
4. The fee guidelines for disputed services are found in 28 TAC §134.203.
5. 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."
6. 28 TAC §134.203 (b)(1) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."
7. CPT code 99213 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."

A review of the submitted report supports an expanded problem focused examination and medical decision making of low complexity; therefore, the requestor met 2 of the 3 key components. The DWC finds the requestor is due reimbursement for code 99213.

8. Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
 - (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.
 - (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the DWC had been using this MEI annual percentage adjustment: The 2006 DWC conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) DWC conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

The 2019 DWC Conversion Factor is 59.19

The 2019 Medicare Conversion Factor is 36.0391

Per Box 32 of the CMS-1500, the disputed service was rendered in zip code 75043, that has a Medicare locality of Dallas, Texas.

The Medicare participating amount for code 99213 at locality Dallas, Texas is \$75.69

Using the above formula, the DWC finds the MAR is \$124.31. The respondent paid \$0.00. As a result, reimbursement of \$124.31 is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$124.31.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of \$124.31 plus applicable accrued interest per 28 Texas Administrative Code §134.130 , due within 30 days of receipt of this Order.

Authorized Signature

		2/27/2020
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 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.