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
Elite Healthcare Fort Worth

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-21-0755-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 8, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These bills were previously submitted in a timely manner. Please review the attached documentation any pay according to the TDI guidelines."

Amount in Dispute: $125.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Clinical Validation (CV) team has completed their review of the bill in question and determined that the bill priced correctly."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 6, 2020	Office visit	$125.62	$125.62

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 §134.203 sets out the procedures for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 150 – Payment adjusted because the payer deems the information submitted does not support this level of service
   - 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly

Issues

1. Is the insurance carrier's position supported?
2. Is the insurance carrier's denial supported?
3. What rule is applicable to reimbursement?

Findings

1. The insurance carrier's response details the requirements of HCPCS code 99214. The code that was submitted and adjudicated by the carrier was 99213. The carrier's position regarding code 99214 is not applicable to this dispute and will not be considered.
2. The insurance carrier denied the disputed services as the level of service not being supported. The submitted code 99213 is defined as "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity." 28 TAC 134.203 (b) states in pertinent part for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply 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.

   Review of the submitted "Encounter" based on the applicable Medicare coding policy (95 Guidelines) for the date of service finds the reported history is *expanded problem focused*, the review of the symptoms is *comprehensive*, the medical decisions is *straightforward*. These findings support the submitted code of 99213. The carrier's denial is not supported. The allowable is calculated below.

3. 28 TAC 134.203 (c) states in pertinent part 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 the annual conversion factor.

   The physician fee schedule allowable for code 99213 for the date of service in dispute is $75.16 which is multiplied by the amount of the workers compensation conversion factor divided by the Medicare conversion factor (60.32/36.0896) which equals $125.62. This is the recommended allowance.

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 established payment is due. As a result, the amount ordered is $125.62.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $125.62, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

		March 8, 2021
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.