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 NORTH DALLAS

Respondent Name
CONTINENTAL CASUALTY CO

MFDR Tracking Number
M4-21-1228-01

Carrier's Austin Representative
Box Number 57

MFDR Date Received
MARCH 17, 2021

REQUESTOR'S POSITION SUMMARY

"The attached date of service was not paid in full. These services were unnecessarily reduced."

Amount in Dispute: $12.50

RESPONDENT'S POSITION SUMMARY

"After review, the carrier stands by the original payment amount as it was paid per fee guidelines."

Response Submitted By: Sedgwick Claims Management Services, Inc

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 11, 2021	CPT Code 99213 Office Visit	$12.50	$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

1. 28 Texas Administrative Code (TAC) §133.307, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.

- 309-The charge for this procedure exceeds the fee schedule allowance.
- N600-Adjusted based on the applicable fee schedule for the region in which the service was rendered.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3-Additional payment made on appeal/reconsideration.
- 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

Is the requestor due additional reimbursement for CPT code 99213?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $12.50 for CPT code 99213 rendered on January 11, 2021.
2. The respondent issued payment of $163.14 based upon the fee guideline.
3. The fee guidelines for disputed services are found in 28 TAC §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."

   CPT code 99213 is described as, "Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter."

   The division finds the submitted report supports billing code 99213; therefore, reimbursement is recommended per the fee guideline.

5. 28 TAC §134.203(c)(1) states "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."

   28 TAC §134.203(c)(2) states "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 Division had been using this MEI annual percentage adjustment: The 2006 Division 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) Division 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 DWC conversion factor for 2021 is 61.17.
   - The Medicare conversion factor for 2021 is 34.8931.
   - Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 75006 which is located in Carrollton, Texas; therefore, the Medicare locality is "Dallas, Texas."
   - The carrier code for Texas is 4412 and the locality code for Dallas is 11.

- The Medicare participating amount for CPT code 99213 at this locality is $93.06.

Using the above formula, the MAR is $163.14. The respondent paid $163.14. The difference between MAR and amount paid is $0.00.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is not 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

		04/23/2021
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 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.