TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Dr. Michael Lopez

Respondent Name
American Zurich Insurance Co.

MFDR Tracking Number
M4-21-2382-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
August 20, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 5, 2021	CPT Code 99214	$227.43	$0.00
	Total	$227.43	$0.00

Requestor's Position

"These bills were previously submitted in a timely manner. Please review the attached documentation any pay according to the TDI guidelines."

Amount in Dispute: $227.43

Respondent's Position

"The provider is not entitled to any additional reimbursement."

Response Submitted by: Flahive, Ogden & Latson

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code §133.307 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.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- P12-Workers' compensation jurisdictional fee schedule adjustment.
- 168-Payment denied as service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.
- 309-The charge for this procedure exceeds the fee schedule allowance.
- 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 American Zurich Insurance Company's denial based on the documentation does not support the level of service billed supported?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $227.43 for CPT code 99214 rendered on April 5, 2021.

   The respondent denied reimbursement for CPT code 99213 based upon reason codes "150," "P12," "309," and "168." (description listed above)

   The fee guidelines for disputed services are found in 28 TAC §134.203.

   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 99214 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 moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter."

   The division finds the submitted report does not support billing code 99214, specifically moderate level of medical decision making. The requestor did not document the time spent for the encounter to support 30-39 minutes; therefore, reimbursement is not recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	09/21/2021 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.