



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

CLARENCE J WOLINSKI III

**Respondent Name**

ACE AMERICAN INSURANCE COMPANY

**MFDR Tracking Number**

M4-22-0353-01

**Carrier's Austin Representative**

Box Number 15

**DWC Date Received**

October 20, 2021

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 15, 2021	99214	\$255.00	\$221.76
<b>Total</b>		\$255.00	\$221.76

### Requestor's Position

"I have attached the copy of our reconsideration and 99214 is the correct level based on documentation and Total MDM elements score, two of the three elements were meet per our Auditor's review. Please review that attached dispute regarding 99214."

**Amount in Dispute:** \$255.00

### Respondent's Position

"The carrier is having the bill reprocessed. However, at the current time, the carrier stands on his position as outlined in its EOBs that are provided in the provider's DWC-60 packet. That position is that the information submitted with the provider's bill did not support the level of service to support CPT Code 99214."

**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 (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 TAC §133.20 sets out the medical bill submission procedures for health care providers.
4. TLC §408.027 sets out the rules for timely submission of claims by health care providers.

### Denial Reasons

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

- CAC-150-Payer deems the information submitted does not support this level of service.
- Note: After review of the bill and the medical records this service is best described by 99213. Submitted documentation did not meet at least 2 of the 3 medical decisions making.
- 5352 – Service reduced/denied as level of E&M code submitted is not supported by documentation.
- 29 – The time limit for filing has expired
- P12 – Workers' compensation jurisdictional fee schedule adjustment

### Issues

1. Is the Insurance Carrier's denial reason for timely filing supported?
2. Is the insurance Carrier's denial reason of 150 supported?
3. Is the Requestor entitled to reimbursement?

### Findings

1. The requestor seeks reimbursement for CPT Code 99214 rendered on April 15, 2021. The insurance carrier denied/reduced the disputed service with codes 29, 5352 and note (description provided above.)

28 TAC §133.20(b) requires that, except as provided in TLC §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided."

The requestor submitted a copy of an EOB dated May 15, 2021 to support that the medical bill was submitted to the insurance carrier within the 95-day timeframe. For that reason, the DWC finds that the requestor submitted sufficient documentation to support that a medical bill was submitted within 95-days from the date the service was provided. Therefore, pursuant to TLC §408.027(a), the requestor has not forfeited the right to reimbursement due to timely submission of the medical bill for the service in dispute.

2. The insurance carrier denied/reduced the service in dispute with reduction code 150 (description provided above.)

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 at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or 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 moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family."

A review of the submitted medical report supports billing code 99214; therefore, reimbursement is recommended.

Per 28 TAC §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..."

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

The 2021 DWC Conversion Factor is 61.17

The 2021 Medicare Conversion Factor is 34.8931

Per the EOBs, the services were rendered in Wichita Falls, TX; therefore, the Medicare locality is "Rest of Texas."

The Medicare Participating amount for CPT code 99214 at this locality is \$126.50.

Using the above formula, the DWC finds the MAR is \$221.76. The respondent paid \$0.00. As a result, reimbursement of \$221.76 is recommended.

3. The DWC finds that the requestor is therefore entitled to reimbursement in the amount of \$221.76.

### 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 established that reimbursement of \$221.76 is due.

### **Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor \$221.76 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

### **Authorized Signature**

_____	_____	December 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 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](http://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](mailto: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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).