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
KEVIN C. LUNDE, MD

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-22-0691-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
December 8, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 20, 2021	69210-LT	$130.00	$0.00
	Total	$130.00	$0.00

Requestor's Position

"The claim for DOS 08/20/2021 was originally filed to Texas Mutual Workers Comp they denied needing records, so a corrected claim was filed with the records. They only paid on one line item the 99221 25 and denied the 69210. Another corrected claim was filed with a modifier LT added to the 69210 but the claim was denied as a duplicate because they only accept one corrected claim. Please review the attached records and EOB's."

Amount in Dispute: $130.00

Respondent's Position

"Dr. Kevin Lunde, M.D., performed service code 69210-LT - remove impacted earwax and billed Texas Mutual with place of service 11 (office visit). (Attachment) Texas Mutual audit staff reviewed its billing and denied the surgical procedure for incorrect place of service with message code 892 and 225 and provided explanation on EOB 'documentation submitted does not support the surgical procedure was performed in a doctor's office. Review place of service.' (See pg. 13 DWC60) The requestor's documentation supports the procedure performed was provided in an operating room, not in the doctor's office. For this reason, Texas Mutual maintains its position."

Response Submitted by: Texas Mutual Insurance Company

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 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.10 sets out the required billing forms/formats.

Denial Reasons

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

- 892,225 – DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE SURGICAL PROCEDURE WAS PERFORMED IN A DOCTOR'S OFFICE. REVIEW THE PLACE OF SERVICE.
- CAC-P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- CAC-W3 & 350 – IN ACCORDA□CE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- CAC-16 – CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION.
- DC4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION.
- 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION
- 892 – DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE INCLUDING CURRENT CPT CODE DESCRIPTIONS/INSTRUCTIONS.

Issues

1. Are the Insurance Carrier's denial reasons supported?
2. Is the Requestor entitled to reimbursement?

Findings

1. Per 28 TAC §134.203(b)(1), "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."

   The requestor seeks reimbursement for CPT Code 69210 defined as "Removal impacted ear wax…" rendered on August 20, 2021. The insurance carrier denied/reduced the disputed services with denial reduction codes, "892, 225, CAC-16", (description provided above).

Review of the medical bill documents that the requestor billed CPT Code 69210 with place of service 11 and CPT Code 99221-25 with place of service 21. Place of service 11 identifies that the services were rendered in an office setting and place of service 21 identifies that the services were rendered in a facility setting. The medical documentation documents that the services were rendered in a facility setting. Reimbursement for the same services rendered in a facility setting versus an office setting differs per the DWC medical fee guidelines.

28 TAC §133.10 states, "(f) All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form. (1) The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care: (P) place of service code(s) (CMS-1500, field 24B) is required…"

Review of the medical bill documents that the requestor billed CPT Code 69210 with place of service 11 and CPT Code 99221-25 with place of service 21. Review of the documentation does not support that CPT Code 69210 was provided in an office setting. The DWC therefore finds, that the requestor did not meet the requirements of 28 TAC 133.10 and therefore is not entitled to reimbursement for the services in dispute.

2. The DWC finds that the requestor has submitted insufficient documentation to support that the disputed services were rendered as billed, as a result, $0.00 is 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.

The DWC finds the requester has established that reimbursement of $0.00 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

		January 26, 2022
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. 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.