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
ARK-LA-TEX SPINE APMC

Respondent Name
ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number
M4-22-1567-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
March 29, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 08, 2021	Code 99213	$200.00	$0.00

Requestor's Position

"This letter is to request a review of a workers' compensation adjustment pursuant to the Louisiana Workers' Compensation Fee Schedule. The Louisiane Medical Fee Scheduele is promulgated by RS 23:1034.2 and can be found in Title 40, Part 1 Chapter 25 through 51 of the Lousisana Administrtive Code."

Amount in Dispute: $200.00

Respondent's Position

"The Provider filed a DWC-60 seeking Medical Fee Dispute Resolution for a date of service of September 8, 2021. The Providers' DWC-60 indicates that the Provider billed under CPT Code 99213 and is seeking reimbursement of $200.0. However, the CMS-1500 indicates that the Provider billed under 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 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §133.20 sets out the health care providers billing procedures.

3. Texas Labor Code, Chapter 408.0272 sets out exceptions for untimely submission of claims.

Denial Reasons

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

- 90168 – Payment adjusted because the payer deems the information submitted does not support this level of service
- 150 – Payment adjusted because the payer deems the information submitted does not support this level of service
- 5352 – CV: Service reduced/denied as Level of E&M code submitted is not supported by documentation
- 90202 – Previously paid. Payment for tis claim/service may have been provided in a previous payment
- B13 – Previously paid. Payment for this claim service may have been provided in a previous payment
- 247 – A payment or denial has already been recommended for this service
- 90168 – 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
- P12 – Workers Compensation Jursidictional fee schedule adjustment

Issues

1. Is ARK-LA-TEX SPINE APMC entitled to reimbursement?

Findings

1. The requestor is seeking reimbursement for September 08, 2021 CPT Code 99213 in the amount of $200.00

   Review of the submitted documentation finds:

   - Requestor provided a CMS 1500 dated March 22, 2022 for date of service September 08, 2021 for CPT Code 99214

- Explanation of benefits dated September 10, 2021for date of service September 08, 2021for CPT Code 99214
- Explanation of benefits dated October 12, 2021 for date of service September 08, 2021 for CPT Code 99214
- Explanaton of benefits dated November 08, 2021 for date of servie September 08, 2021 for CPT Code 99213
- No CMS 1500 provided by the requestor for dates of service September 08, 20021 for CPT code 99213 in dispute

Per 28 TAC §133.20(a) states "The health care provider shall submit all medical bills to the insurance carrier except when billing the employer in accordance with subsection (j) of this section. (b) Except as provided in Labor Code §408.0272(b). Review of the submitted documentation finds the requestor did not provide any proof that the medical bill submitted to the insurance carrier for date of service September 08, 2021 for disputed code 99213 in accordance with 28 TAC §133.20 and Labor Code §408.0272. Therefore, no reimbursement is due.

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 additional reimbursement is due.

Authorized Signature

[redacted]	[redacted]	April 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.