



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

PEAK INTEGRATED HEALTHCARE

Respondent Name

INDEMNITY INSURANCE COMPANY

MFDR Tracking Number

M4-22-1692-01

Carrier's Austin Representative

Box Number 15

DWC Date Received

April 5, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 11, 2022	99213	\$45.50	\$45.50
	Total	\$45.50	\$45.50

Requestor's Position

"Office visits are recommended as determined to be medically necessary. Evaluation and management outpatient visits to the offices of medical doctors play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged."

Amount in Dispute: \$45.50

Respondent's Position

"...we have escalated the bills in question for manual review to determine if additional monies are owed. Supplemental response will be provided once the bill auditing company has finalized their review."

Response Submitted by: Gallagher Bassett Services, Inc.

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 §134.203 sets out the fee guideline for professional medical services.

Denial Reasons

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

- P12 & 90223 – Workers' compensation jurisdictional fee schedule adjustment.
- 4053 – Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting.

Issues

1. Were the services rendered in a facility setting?
2. What is the definition of CPT Code 99213?
3. Is the Requestor entitled to additional reimbursement for CPT Code 99213?

Findings

1. The requestor seeks additional reimbursement in the amount of \$45.50 for CPT Code 99213 rendered on January 11, 2022. The insurance carrier denied/reduced the dispute service with denial reduction code 4053 (description provided above.)

Review of the medical bill, CMS-1500 documents that the requestor billed for CPT Code 99213 with place of service code "11" which indicates an office setting. The DWC finds that the insurance carrier's denial reason is not supported.

2. 28 TAC §134.203(b)(1) states, "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."

CPT Code 99213 is defined 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."

3. 28 TAC §134.203 states in pertinent part, "(c) 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 service was rendered in 2022.
- The 2022 DWC Conversion Factor is 62.46
- The 2022 Medicare Conversion Factor is 34.6062
- Per the medical bills, the services were rendered in zip code 75043, TX; therefore, the Medicare locality is "Dallas, Texas."
- The Medicare Participating amount for CPT code 99213 at this locality is \$92.65.
- Using the above formula, the DWC finds the MAR is \$167.22.
- The insurance carrier paid \$121.72.
- Additional reimbursement of \$45.50 is recommended.

The DWC finds that the requestor is entitled to an additional payment in the amount of \$45.50.

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 additional reimbursement of \$45.50 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 \$45.50 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

July 7, 2022
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 electrónico CompConnection@tdi.texas.gov.