TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
CLINIC OF NORTH TEXAS LLP

Respondent Name
TRUCK INSURANCE EXCHANGE

MFDR Tracking Number
M4-22-1719-01

Carrier's Austin Representative
Box Number 14

DWC Date Received
April 8, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 1, 2021	99214	$255.00	$221.76
	Total	$255.00	$221.76

Requestor's Position

"99214 CPT Code: Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and code selection is based on the MDM (Medical Decision-Making Level). I have attached the E/M Audit provided by our certified coder and the audit shows that MDM level was Moderate. At least 2 elements must be met or exceeded, 2 elements were met, Problem score: Moderate and Risk score: Moderate. 99214 was billed at the correct level, please reprocess 99214 for payment."

Amount in Dispute: $255.00

Respondent's Position

The Austin carrier representative for Truck Insurance Exchange is Courtney James Triggs. Courtney James Triggs was notified of this medical fee dispute on April 12, 2022. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under 28 TAC §133.307(d)(1).

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, effective March 1, 2008, sets out the reimbursement guidelines for professional services.

Denial Reasons

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

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 790 – This charge was reimbursed in accordance with the Texas Medical Fee Guideline.
- 205 – This charge was disallowed as additional information/definition is required to clarify service/supply rendered.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- Note: The billed established patient code 99214, which requires a moderate level of medical decision making, but documents supports for low complexity.
- NOTE: Medical record does not support for the billed CPT Code 99214. Since it is a no down code state denied CPT to disallow the charges. Re-evaluation may be done upon submission of sufficient medical records supporting the billed code.

Issues

1. What is the definition of CPT Code 99214?
2. Is the requestor entitled to reimbursement for the service in dispute?

Findings

1. The requestor seeks reimbursement for CPT Code 99214 rendered on November 1, 2021. The insurance carrier denied/reduced the disputed service due to documentation not supporting the level of service billed.

   Per 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." 28 TAC §134.203."

   CPT Code 99214 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 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."

A review of the submitted report supports the billing of CPT code 99214. As a result, the requestor is entitled to reimbursement for the service in dispute.

2. 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 disputed service was rendered in 2021.
   - The 2021 DWC Conversion Factor is 61.17
   - The 2021 Medicare Conversion Factor is 34.8931
   - Per the medical bills, the services were rendered in zip code 76302; 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.
   - The requestor is due $221.76.

   The DWC finds that the requestor is therefore entitled to reimbursement in the amount of $221.76. Therefore, this amount 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 $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

		June 22, 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.