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
LOUIS F. PUIG MD

Respondent Name
ARCH INDEMNITY INSURANCE COMPANY

MFDR Tracking Number
M4-22-1935-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
May 4, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 7, 2022	99203	$224.74	$210.38
	Total	$224.74	$210.38

Requestor's Position

"A corrected medical bill correcting the level of service was submitted, and an EOB was received again denying payment for the following reason: 'Original payment decision is being maintained.' Our billing office resubmitted the medical bill, disputing the reason codes chosen, providing documentation to substantiate the claim, and re-asserting the payments due for specific CPT/HCPCS codes on the bill. The insurance company sent a second EOB, denying full or partial payment. The second EOB gave the reason for non-payment as: 'Payment or denial has been already recommended for this service.'"

Amount in Dispute: $224.74

Respondent's Position

The Austin carrier representative for ARCH Indemnity Insurance Company is Flahive Ogden & Latson. Flahive Ogden & Latson was notified of this medical fee dispute on May 10, 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 §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 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 – Workers' compensation jurisdictional fee schedule adjustment.
- 90202 & 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 & 150 – 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 that this claim was processed properly.

Issues

1. Are the insurance carrier's denial reasons supported?
2. Is the Requestor entitled to reimbursement for CPT Code 99203?

Findings

1. The requestor seeks reimbursement in the amount of $224.74 for CPT Code 99203 rendered on February 7, 2022. The insurance carrier denied/reduced the dispute service with denial reduction code 90168 & 150 (description provided above.)

   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 99203 is defined as "Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-44 minutes of total time is spent on the date of the encounter."

   The requestor submitted an office visit note for the date of service in dispute. The DWC finds that the documentation submitted supports the billing of CPT Code 99203. As a result, the insurance carrier's denial reasons are not supported, and the requestor is therefore entitled to reimbursement for CPT Code 99203.

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 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 77505; therefore, the Medicare locality is "Houston, Texas."
   - The Medicare Participating amount for CPT code 99203 at this locality is $116.56.
   - Using the above formula, the DWC finds the MAR is $210.38.
   - The insurance carrier paid $0.00.
   - Reimbursement of $210.38 is recommended.

   The DWC finds that the requestor is entitled to payment in the amount of $210.38.

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 $210.38 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 $210.38 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

____________________	____________________	July 7, 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.