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

General Information

Requestor Name
PEAK INTEGRATED HEALTHCARE

Respondent Name
ARCH INDEMNITY INSURANCE COMPANY

MFDR Tracking Number
M4-22-1945-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
May 9, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 30, 2021	99204	$293.34	$293.34
	Total	$293.34	$293.34

Requestor's Position

"Office visits are recommended as determined to be medically necessary. This claim should be paid IN FULL WITHOUT ANY FURTHER DELAY. This is an approved case, and all claims are to be paid in full. Also, research Rule 134.130 regarding interest that is to be paid. THESE ARE NOT DUPLICATES. If you have any questions or concerns, please, do not hesitate to contact my office."

Amount in Dispute: $293.34

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 17, 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:

- 90166 - PAYMENT ADJUSTED BECAUSE THE PYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE.
- 90563 - ORIGINAL PAYMENT DECISION IS BING MAINTAINED. UPON REVIEW. IT WAS DETERMINED THAT THIS CLAIM WAS PROESSED PROPERLY
- 90950 - THIS BILL IS A RECONSIDERATIONOF A PREVIOUSLY REVIEWED BILL, ALLOWANCE AMOUNTS REFLECT ANY CHANGES TO THE PREVIOUS PAYMENT
- 5263 – ADDITIONAL ALLOWANCE IS NOT RECOMMENDED AS THIS BILL WAS REVIEWED IN ACCORDANCE WITH STATE GUIDELINES, USUAL AND CUSTOMARY POLICIES, PROVIDR'S CONTRACT.
- 150 - PAYMENT ADJUSTED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE.
- 5407 - CV RECONSIDERATION NO ADDITINAL ALLOWANCE RECOMMENDED THIS BILL AND SUBMITTED DOCUMENTATION HAVE EEN RE-EVALUATED BY CLINICAL VALIDATION.
- 5721 - TO AVOID DUPLICATE BILL DENIAL FOR ALL RECONSIDERATIONS/ ADJUSTMENTS/ ADDITIONAL PAYMENT REQUESTS SBMIT A COPY OF THIS EOR OR CLEAR NOTATION.
- 5246 - AFTER REVIEW OF THE BILL AND THE MEDICAL RECORD THIS SERVICE IS BEST DESCRIBED BY 99203. SUBMITTED DCUMENTATION DID NOT MEET AT LEAST 2 OF THE 3 MEDICAL DECISIONS. ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT AS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

Issues

1. Does the documentation support the billing of CPT code 99204?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 99204 rendered on September 30, 2021. The insurance carrier's denial reasons are indicated above.

   The fee guidelines for disputed services are found in 28 Texas Administrative Code §134.203.

   28 Texas Administrative Code §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."

   CPT code 99204 is described as "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family."
   A review of the submitted medical report supports billing code 99204; therefore, reimbursement is recommended.

   Review of the office visit note supports the billing of CPT Code 99204. As a result, the insurance carrier's denial reason is not supported, and the requestor is entitled to reimbursement for the disputed service.

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 2021 DWC Conversion Factor is 61.17
   - The 2021 Medicare Conversion Factor is 34.8931
   - Per the medical bills, the services were rendered in 76112; therefore, the Medicare locality is "Fort Worth Texas."
   - The Medicare Participating amount for CPT code 99204 at this locality is $167.33.
   - Using the above formula, the DWC finds the MAR is $293.34.
   - The respondent paid $0.00.
   - Reimbursement of $293.34 is recommended.

The DWC finds that the requestor is therefore entitled to $293.34 for CPT Code 99204 rendered on September 30, 2021.

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 $293 .34 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 $293.34 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		August 10, 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.