



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

INTERVENTIONAL PAIN SPECIALIST

Respondent Name

TEXAS WATER CONSERVATION ASSOC.

MFDR Tracking Number

M4-22-2344-01

Carrier's Austin Representative

Box Number 43

DWC Date Received

July 1, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 1, 2021	99214	\$246.82	\$233.51
	Total	\$246.82	\$233.51

Requestor's Position

"Sedgwick called me back and spoke with Sara, I told her that York told me that Sedgwick was the bill review that will now do the processing of the claims and that I needed to call Sedgwick. Sara told me that the transfer of this patients Workers Comp case was still in processing and has not been completed still needs about 7 to 10 days to complete that is why York cannot fine any claims on file. Sara told me to just keep faxing the claims to fax# 866-548-2637 and the claims will get processed after the WC case completes the merge transfer."

Amount in Dispute: \$246.82

Respondent's Position

The Austin carrier representative for Texas Water Conservation District is JI Specialty Services, Inc. JI Specialty Services Inc., was notified of this medical fee dispute on July 6, 2022. Rule §133.307(d)(1) states that if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC 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 Texas Administrative Code (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:

- 18 – Exact duplicate claim/service.
- Note – A payment denial has already been recommended for this service. Billing is a duplicate of other services performed on same day. Duplicate bill.

Issues

1. Is the Insurance Carrier's denial reason supported?
2. What is the definition of CPT Code 99214?
3. What is the fee guideline for CPT Code 99214?
4. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 99214 rendered on December 1, 2021. The insurance carrier denied the disputed service with denial reduction codes indicated above.

Review of the documentation submitted, finds that the insurance carrier did not provide sufficient documentation to support that CPT Code 99214 was a duplicate bill and/or that payment had been recommended for this service. As a result, the insurance carrier's denial reason is not supported and the disputed service is reviewed pursuant to 28 TAC §134.203.

2. The requestor seeks reimbursement for CPT Codes 99214 rendered on December 1, 2021.

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 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."

The DWC finds that the requestor rendered the services as billed, as a result, reimbursement is recommended for the disputed services.

3. The requestor seeks reimbursement for CPT Codes 99214.

Rule §134.203 sets out the reimbursement guidelines for office visits.

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 services were 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 77058; therefore, the Medicare locality is "Houston."
- The Medicare Participating amount for CPT code 99214 at this locality is \$133.20.
- Using the above formula, the DWC finds the MAR is \$233.51.
- The respondent paid \$0.00.
- Reimbursement of \$233.51 is recommended.

4. The DWC finds that the requestor is entitled to reimbursement in the amount of \$233.51. 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 \$233.51 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 \$233.51 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____	_____	<u>October 11, 2022</u>
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 electrónico CompConnection@tdi.texas.gov.