TDI 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
Jerry Grimes

Respondent Name
UMC Health System

MFDR Tracking Number
M4-22-2438-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
July 18, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 21, 2021	99214	$220.00	$220.00
	Total	$220.00	$220.00

Requestor's Position

"I've attached a Fee Dispute Resolution Request."

Amount in Dispute: **$**220.00

Respondent's Position

"...we have escalated the bills in question for manual review to determine if additional monies are owed."

Response submitted by: Gallagher Bassett

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 reimbursement guidelines for professional medical services.

Denial Reasons

- 5405 – This charge was reviewed through the clinical validation program
- 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 this claim was processed properly

Issues

1. Is the insurance carrier's denial supported?

2. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement for professional medical services rendered in December 2021. The insurance carrier denied stating requirements of code not supported by documentation presented.

   Review of the disputed code description found, 99214 - "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."
   Based on this requirement and review of the "Clinic Note" found a moderate level of decision making was documented. The insurance carrier's denial is not supported. The disputed service will be reviewed per applicable fee guideline.

2. DWC Rule 134.203 (c) (1) states in pertinent part, to determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. 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 (conversion factor for disputed date of service).

The maximum allowable reimbursement (MAR) is calculated as the DWC Conversion Factor divided by the Medicare Conversion factor multiplied by the Medicare Physician Fee Schedule amount or 61.17/34.8931 x $126.50 - $221.76.

The requestor is seeking $220.00. 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.

DWC finds the requester has established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that respondent must remit to requestor $220.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		September 13, 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.