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
Lankford Hand Surgery Assn

Respondent Name
Znat Insurance Co

MFDR Tracking Number
M4-23-0625-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
November 10, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 2, 2022	99213	$118.40	$0.00
	Total	$118.40	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR.

Amount in Dispute: $118.40

Respondent's Position

"No additional payment is due to the provider for disputed code 99213-25. The date of service was correctly reimbursed pursuant to the Texas Medical Fee Guidelines for Professional Services.

Response submitted by: The Zenith

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 guidelines for professional medical services.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 97 – The benefit for this service is included in the payment/allowance for another service/procedure performed on this date
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. What rule is applicable to reimbursement of disputed charge?

Findings

1. The requestor is seeking reimbursement of code 99213 - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter for date of service September 2, 2022.

   The medical bill also included the 25 modifier which is defined as significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service.

   The insurance carrier denied the claim line stating disputed service was included in the payment/allowance of another procedure performed on the same date.

   DWC Rule §134.203(b)(1) states in pertinent part for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

   Review of the submitted documentation did not support that the billed evaluation and

management service was "significant and separate" from the primary code, 20600.

Review of the applicable CCI edits found an edit exists between code 99213 ad 20600. The insurance carrier's denial is supported. No additional payment 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 not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

		January 12, 2023
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.