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**
Peak Integrated
Healthcare

**Respondent Name**
Arch Insurance Co

**MFDR Tracking Number**
M4-23-0746-01

**Carrier's Austin Representative**
Box Number 19

**DWC Date Received**
November 23, 2022

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| August 17, 2022 | 99204 | $306.32 | $0.00 |
| August 17, 2022 | 99080-73 | $0.00 | $0.00 |
| | **Total** | $306.32 | $0.00 |

## Requestor's Position

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

**Amount in Dispute:** $306.32

## Respondent's Position

"Our CV team has determined that the provider is  not due any additional allowance for the disputed denial."

Response submitted by: Gallagher Bassett Services

## 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.

- 150 – Payment adjusted because the payer deems the information submitted does not support the 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?

Findings

1. The requestor is seeking reimbursement of professional medical services rendered on August 17, 2022. The insurance carrier denied the medical bill based on level of service not supported.

   DWC Rule 134.203 ((b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

   The requirements of code 99204 are "Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter."

   Review of the submitted medical record did not indicate the time spent with the injured worker. The documented medical decision making was low. The insurance carrier's denial is supported. No 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**

| Signature | Medical Fee Dispute Resolution Officer | January 12, 2023<br>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.