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

Requester Name
Ahmed Khalifa

Respondent Name
Technology Insurance Company Inc

MFDR Tracking Number
M4-23-1629-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
March 10, 2023

Requester's Position

"The attached claim for work comp treatment and services has been reduced/cut inappropriately based on the MAR for the CPT Codes billed according to DWC rule 133 and 134."

Amount in Dispute: $413.44

Respondent's Position

"The documentation showed nature of presenting problem: moderate – 2 chronic condition, complexity of data review: straightforward – none; and risk of complications; low – therapy is present. Therefore, the medical documentation does not support medical decision-making key component of the billed code 99205."

Response Submitted by: Downs Stanford

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 8, 2022	99205	$413.44	$0.00
September 8, 2022	95886	$0.00	$0.00
September 8, 2022	95913	$0.00	$0.00
	Total	$413.44	$0.00

Findings and Decision

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).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.203 sets the reimbursement guidelines for the disputed service.

3. The respondent reduced/denied reimbursement for the disputed services based on the following claim adjustment reason codes:
    - 16 – Claim/service lacks information or has submission/billing error(s).
    - 205 - This charge was disallowed as additional information/definition is required to clarify service/supply rendered.
    - 350 – Bill has been identified as a request for reconsideration or appeal.
    - M127 – Missing patient medical record for this service.
    - MA27 – Missing/incomplete/invalid type of bill.
    - MA30 – Missing/incomplete/invalid type of bill.
    - N179 – Additional information has been requested from the member. The charges will be reconsidered upon receipt of information.
    - W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. Is the requester entitled to reimbursement for the disputed services rendered on September 8, 2022?

Findings

1. The requestor is seeking reimbursement of Code 99205 - Office or other outpatient visit for the evaluation and management of a new patient which requires a medically appropriate history and/or examination and high medical decision making.

    DWC Rule §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.

Review of the submitted documentation did not support a high medical decision making. The insurance carrier's denial is supported. No payment is recommended.

Conclusion

DWC finds the requester has not established that additional reimbursement is due. As a result, the amount ordered is $0.

Order

Under Texas Labor Code §413.031, it is ordered that the requester is entitled to $0 additional reimbursement for the disputed services.

Authorized Signature

		April 7, 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 512-804-4812.