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
David Adam West

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-23-1658-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 14, 2023

Requester's Position

"The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134."

Amount in Dispute: $413.44

Respondent's Position

"Our supplemental response for the above referenced medical fee dispute resolution is as follows: The bill(s) in question was escalated and the review has been finalized. Our bill audit company has determined no additional monies are due in response to the attached DWC 60."

Response Submitted by: Gallagher Bassett

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 4, 2022	99205	$413.44	$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 Texas Administrative Code §134.203 sets the reimbursement guidelines for the disputed service.

The respondent reduced/denied reimbursement for the disputed services based on the following claim adjustment reason codes:

- 5407 – CV Reconsideration. No additional allowance recommended. This bill and submitted documentation have been re-evaluated by clinical validation.

- 8238 – After review of the bill and the medical record, this service is best described by 99203. Submitted documentation did not meet at least 2 of.

- 150 – Payment adjusted because the payer deems the information submitted does not support the level of service

Issues

1. Does the submitted medical record support the submitted Code 99205?

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 level of medical decision making.

   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.

   Review of the submitted medical record found.

   - The number and complexity of problems addressed was minimal.

   - The risk of complications and/or morbidity or mortality of patient management was low.

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moderate.

Based on this review, the level of decision making is low. The insurance carrier's denial is supported. No payment is recommended.

Conclusion

DWC finds the requestor 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 requestor is entitled to $0 additional reimbursement for the disputed services.

Authorized Signature

		June 19, 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.