



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Peak Integrated Healthcare

**Respondent Name**

Southeastern Freight Lines, Inc.

**MFDR Tracking Number**

M4-23-1764-01

**Carrier's Austin Representative**

Box Number 48

**DWC Date Received**

March 20, 2023

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
10/11/2022	99213	\$167.22	\$0.00
10/11/2022	99080-73	\$15.00	\$0.00
12/15/2022	99213	\$167.22	\$0.00
<b>Total</b>		\$349.44	\$0.00

### Requestor's Position

Regarding DOS 10/11/2022: "This bill still remains unpaid unnecessarily. Please submit for payment."

Regarding DOS 12/15/2022: "This was denied payment due to 'only one visit per day is covered.' This is incorrect... This date of service was denied again for same reason. Please resubmit for payment."

**Amount in Dispute:** \$349.44

### Respondent's Supplemental Position

"Our bill audit company has determined additional monies are owed in the amount of \$167.22. Interest in the amount of \$1.75 has been issued. Attached is a copy of the EOB and payment summaries for your records."

**Response Submitted by:** Gallagher Bassett Services, Inc.

## 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.
3. [28 TAC §129.5](#) sets out the fee guidelines for the DWC73 Work Status Reports.

### Adjustment Reasons

The following claim adjustment codes are found per explanation of benefits submitted:

- 5283 – Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, provider's contract.
- 90563,193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
- 90203, B14 – Payment denied because only one visit or consultation per physician per day is covered.
- 53 – Two evaluations have been inappropriately billed on the same date of service.
- 90950 - This bill is a reconsideration of a previously reviewed bill, allowance amounts reflect any changes to the previous payment.
- 5920 – Fee schedule manually priced at billed charge.

### Issues

1. Has the insurance carrier reimbursed the requestor for the services rendered on October 11, 2022?
2. Has the insurance carrier reimbursed the requestor for the services rendered on December 15, 2022?
3. Is the requestor entitled to additional reimbursement for services in dispute?

### Findings

1. Requestor is seeking reimbursement for CPT code 99213 and 99080-73, rendered on October 11, 2022.

Review of the initial medical bill submitted finds that the requestor billed to the insurance carrier \$167.22 for CPT code 99213 and billed \$15.00 for CPT code 99080-73 for date of service October 11, 2022. Total charges billed for this date of service were \$182.22.

Review of submitted documentation finds an explanation of benefits dated November 4, 2022 and copy of a check issued on November 4, 2022, for payment in full, in the amount of \$182.22.

The DWC finds that the insurance carrier has reimbursed the requestor for services rendered on October 11, 2022.

2. Requestor is seeking reimbursement for CPT code 99213 rendered on December 15, 2022.

Review of submitted medical bills, finds that the requestor billed to the insurance carrier \$167.22 for CPT code 99213 rendered on December 15, 2022.

Review of submitted documentation finds an explanation of benefits issued on January 30, 2023, denying payment for CPT code 99213 rendered on December 15, 2022, due to "Two evaluations have been inappropriately billed on the same date of service." The insurance carrier continued to deny this date of service for the same reason upon first reconsideration request, as evidenced by the explanation of benefits issued on February 24, 2023.

Review of the documentation submitted with insurance carrier's supplemental response to this dispute, finds an explanation of benefits and copy of check issued on April 11, 2023, in the amount of \$167.22 for reimbursement of CPT code 99213 rendered on December 15, 2022.

The DWC finds that the insurance carrier has reimbursed the requestor for services rendered on December 15, 2022.

3. Requestor is seeking reimbursement in the total amount of \$349.44 for services rendered on October 11, 2022 and on December 15, 2022.

As discussed above, review of submitted documents finds that the insurance carrier issued payment in the total amount of \$349.44 for dates of service in dispute. The reimbursements equal to the full amounts charged for the disputed dates of service.

The DWC finds that no additional reimbursement is due.

### 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 requestor has not established that additional reimbursement is due.

### **Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to \$0.00 additional reimbursement for the disputed services.

## Authorized Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

July 13, 2023

\_\_\_\_\_  
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](http://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](mailto: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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).