



## Medical Fee Dispute Resolution Findings and Decision General Information

**Requester Name**

DAVID ADAM WEST, DO

**Respondent Name**

ZURICH AMERICAN INSURANCE COMPANY

**MFDR Tracking Number**

M4-23-1884-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

March 31, 2023

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 24, 2023	99205-95	\$433.11	\$0.00
<b>Total</b>		\$433.11	\$0.00

### Requester's Position

"WORK COMP TREATMENT AND SERVICES OFFICE CONSULTATION NO PAYMENT RECEIVED."

**Amount in Dispute:** \$433.11

### Respondent's Position

"...the bills in question were escalated and a review completed. Our bill audit company has determined no further payment is due. The rationale for this determination is found below... Rationale: CV has reviewed the bill and appeal documentation [Appeal letter] and will uphold previous denial reduction of \$433.77."

**Response Submitted by:** Gallagher Bassett

## 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 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 TAC §133.30 sets out the Telemedicine and Telehealth Services.

### Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 90563 & 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- B14 – Payment denied because only one visit or consultation per physician per day is covered.
- 5283 – Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, provider's contract.
- 90168 & 150 – Payment adjusted because the payer deems the information submitted does not support this level of service.
- 3452 – Modifier 95 synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system.
- 5352 –CV: Service reduced/denied as level of E&M code submitted supported by documentation.

### Issues

Is the insurance carrier's denial of payment supported?

### Findings

The requestor seeks reimbursement for CPT Code 99205-95 in the amount of \$433.11 rendered on January 24, 2023. The insurance carrier denied the payment of the office visit with reduction codes indicated above.

The requestor billed CPT Code 99205 to identify that a consultation was rendered on the disputed date of service. The requestor appended modifier -95 that identifies that the consultation was conducted via telehealth.

Review of the submitted medical records, titled, "Consultation Report" does not document that the patient was consulted via a telemedicine visit. The DWC finds that the insurance carriers denial reasons are supported.

Per 28 TAC §133.30 a health care provider may bill and be reimbursed for telemedicine and telehealth services regardless of the geographical area or location of the injured employee. Telehealth and telemedicine services are billed as professional services. Reimbursement for professional services is established by the Medical Fee Guideline for Professional Services, 28 TAC §134.203.

The DWC finds that the requestor has not established that reimbursement is due for CPT Code 99205-95 rendered on January 24, 2023.

### 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.

The DWC finds the requester has established that reimbursement of \$0.00 is due.

## **Order**

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

### **Authorized Signature**

_____	_____	June 16, 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](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 512-804-4812.