Division of Workers' Compensation

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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Peak Integrated Healthcare

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-23-2241-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
May 9, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 8, 2023	99213	$174.71	$174.71
March 8, 2023	99080-73	$15.00	$15.00
February 27, 2023	99361-W1	$113.00	$113.00
	Total	$302.71	$302.71

Requestor's Position

The requestor did not submit a position statement with this request for medical fee dispute. They did submit a copy of their reconsideration that states, "This bill was denied "for the 99361 not being a valid procedure code", however the 3/8/2023 office visit and DWC-73 was not paid or denied and should be paid in full.. This is incorrect. We have been treating for the same compensable injury and received payments for all other office visits."

Amount in Dispute: $302.71

Respondent's Position

The Austin carrier representative for Texas Mutual is Texas Mutual. The representative

was notified of this medical fee dispute on May 16, 2023.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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 §133.307 sets out the guidelines for the resolution of medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services.
4. 28 Texas Administrative Code §129.5 sets out the reimbursement of work status reports.

Denial Reasons

Neither party submitted an explanation of benefits in support of adjudication of the disputed claim.

Issues

1. What is the rule applicable to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of professional medical services rendered on March 8, 2023 and a team conference rendered on February 27, 2023. The insurance carrier returned the claim on May 3, 2023 with the comment, "99361 is not a valid procedure code. Please replace it with a valid and applicable procedure code."

   DWC 28 TAC §134.204 (e)(4)(A)(i) states, "CPT code 99361. Reimbursement to the treating doctor shall be $113. Modifier "WI" shall be added." The return of the claim

for invalid code is not supported. The disputed services will be reviewed per applicable fee guidelines.

DWC 28 TAC §134.203 (c)(1) & (2) states in pertinent parts, (c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. For service categories of Physical Medicine and Rehabilitation, when performed in an office setting, the established conversion factor to be applied is date of service annual conversion factors. The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors and shall be effective January 1st of the new calendar year.

The following formula represents the calculation of the DWC MAR at §134.203 (c)(1)&(2).

(DWC Conversion Factor ÷ Medicare Conversion Factor) x Medicare Payment = MAR

- 99213 – 64.83/33.8872 x $91.33 (location Dallas, Texas) = $174.72
- 99080 -73. Reimbursement is $15 per DWC Rule 28 TAC §129.5(j).
- 99361 -W1. Reimbursement is $113.00 per DWC Rule 28 TAC §134.204(e).
- Total MAR = $302.72.

2. The total allowable DWC fee guideline is $302.72. The requestor is seeking $302.71. This amount is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has established payment is due. The amount ordered is $302.71.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Texas Mutual must remit to Peak Integrated Healthcare $302.71 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 29, 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 in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified 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.