



Medical Fee Dispute Resolution Findings and Decision General Information

Requestor Name

PEAK INTEGRATED HEALTHCARE

Respondent Name

NORTH RIVER INSURANCE COMPANY

MFDR Tracking Number

M4-23-2519-01

Carrier's Austin Representative

Box Number 53

DWC Date Received

May 31, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 2, 2023	99213 and 99080-73	\$189.71	\$0.00
Total		\$189.71	\$0.00

Requestor's Position

"We disagree that this office visit is unreasonable and unnecessary. Office visits are necessary for compensable injury."

Amount in Dispute: \$189.71

Respondent's Position

"Enclosed please find the PLN-11 with peer review filed 09/07/2022 disputing the extent of Claimant's compensable injury. A copy of the PLN-11 and peer review upon which the PLN-11 is based was delivered to the requestor... The EOBs delivered to the requestor and included in the provider's request for medical dispute resolution demonstrate that the medical bills were denied because the services rendered were unreasonable and/or unnecessary as opined by Christopher Roach, M.D."

Response Submitted by: Hoffman Kelley Lopez, LLP

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 Texas Administrative Code (TAC) §133.305 sets out the procedures for resolving medical disputes.
3. 28 TAC §19.2005 sets out the standards of utilization review.

Denial Reasons

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

- 309 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
- P12 – WORKERS COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 5076 – YOUR TREATMENT/BILLING IS UNREASONABLE OR UNNECESSARY AS THERE IS ADEQUATE MEDICAL INFORMATION OR UTILIZATION REVIEW NON-CERTIFICATION TO SUPPORT THIS DECISION.

Issues

1. Does the respondent's position statement include the refusal justifications that were given to the requestor before the MFDR request was filed?
2. What laws govern the contested services?
3. Is the denial reason 5076 for CPT Codes 99213 and 99080-73 justified by the insurance carrier?
4. Is the Requestor qualified for reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Codes 99213 and 99080-73 rendered on January 2, 2023.

The insurance carrier states, "The Carrier investigation revealed that these disputed medical conditions and diagnoses did not arise out of or flow naturally from and are not related to your compensable injury. The carrier enclosed the July 22, 2022 peer review report from Dr Christopher Roach, MD with the PLN-11."

28 TAC §133.307(d)(2)(F) states "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

The DWC concludes that the respondent provided a position summary that included new justifications for denial and defenses. Since they are not mentioned on the Explanation of Benefits that was sent along with the DWC060 request, the additional refusal reasons listed on the position summary were not ones that were brought up during the medical bill review process.

The DWC determines that the respondent has waived the right to raise such additional denial reasons or defenses because the respondent did not provide sufficient evidence to MFDR to show that the denial reasons raised in their position summary were presented to the requestor on the EOBs prior to the date the request for medical fee dispute resolution was filed with the DWC.

2. 28 TAC §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."

The requestor billed CPT Code 99213.

- CPT Code 99213 is defined as, "Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter."

The DWC finds that 28 TAC §134.203 applies to the reimbursement of CPT Code 99213.

The requestor billed CPT Code 99080-73.

- CPT Code 99080-73 is described as "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form."

28 TAC §134.239 states, "When billing for a work status report that is not conducted as a part of the examinations outlined in §134.240 and §134.250 of this title, refer to §129.5 of this title."

The DWC finds that 28 TAC §129.5 applies to the reimbursement of CPT Code 99080-73.

3. The requestor seeks reimbursement for CPT Codes 99080-73 and 99213 rendered on January 2, 2023 denied by the insurance carrier with denial reduction code "5076 – Your treatment/billing is unreasonable or unnecessary as there is adequate medical information or utilization review non-certification to support this decision."

The insurance carrier denied payment due to an unresolved medical necessity issue. The insurance carrier notified the requestor of the denial on an explanation of benefits as defined by 28 TAC §133.240.

The insurance carrier also presented supporting documentation to DWC, as required by 28 TAC §133.307 (d)(2)(I). Specifically, the insurance carrier supported that it conducted a utilization review and presented an adverse determination to the requestor as required by 28 TAC §19.2005.

The DWC concludes that an unresolved medical necessity issue exists for the service in dispute. As a result, the DWC finds that good cause exists to dismiss this dispute according to 28 TAC §133.307 (f)(3)(B)

4. The DWC finds that the requestor is not entitled to reimbursement for the disputed services.

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 requestor has established that reimbursement of \$0.00 is due.

Order

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

Authorized Signature

_____	_____	August 17, 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 1-800-252-7031, opción 3 o correo electrónico CompConnection@tdi.texas.gov.