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

Requestor Name
C Perry Marshall

Respondent Name
Amtrust Insurance Co

MFDR Tracking Number
M4-23-3124-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
August 10, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 18, 2022	99214	$334.00	$0.00
	Total	$334.00	$0.00

Requestor's Position

"Under the new rules, procedure code 99214 is well documented and should be paid."

Amount in Dispute: $334.00

Respondent's Position

"…Requestor billed for a higher office visit than performed. Therefore, no reimbursement is owed for the CPT code 99214 because the requirements were not met."

Response submitted by: Downs Stanford PC

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 billing and coding guidelines for durable medical equipment.

Denial Reasons

The insurance carrier reduced or denied the disputed services) with the following claim adjustment codes.

- 16 – Claim/service lacks information or has submission/billing error(s).
- 205 – This charge was disallowed as additional information/definition is required to clarify service/supply rendered.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement of code 99214 – "Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter."

   Review of the submitted medical record did not indicate total time of visit. The requestor states in their position statement, "Dr. Marshall called the Orthopedic Surgeon and discussed the case with him and obtained an appointment." The submitted medical record only indicates, "I called Azalea Ortho and got his appointment with Dr. Bartley…"

   The supported level of decision making is "low."

   The insurance carrier's denial is supported. No payment is recommended.

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 requester has not established that reimbursement 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

Signature	Medical Fee Dispute Resolution Officer	September 11, 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. 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 electronico CompConnection@tdi.texas.gov.