



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Peak Integrated  
Healthcare

**Respondent Name**

AIU Insurance Co.

**MFDR Tracking Number**

M4-23-3281-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

August 23, 2023

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 19, 2022	99361-W1	\$113.00	\$0.00
December 22, 2022	99213	\$167.22	\$0.00
<b>Total</b>		\$280.22	\$0.00

### Requestor's Position

The requestor did not submit a position statement with this request for Medical Fee Dispute Resolution (MFDR). They did submit a copy of their reconsideration dated April 20, 2023 with a handwritten note dated August 23, 2023 that states, "The EOBs we received after the reconsideration shows an allowance was paid. We do not have record of this payment. Please process for payment."

**Supplemental response, November 1, 2023:** "...Please proceed with the MFDR as they did not pay in full."

**Amount in Dispute:** \$280.22

### Respondent's Position

"We are in receipt of the above captioned medical fee dispute resolution. Payment has been made for \$232.06. We have attached a copy of the cleared check and EOB."

**Response submitted by:** Broadspire

## **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 billing and coding guidelines for professional medical services.
3. [28 TAC §134.204](#) sets out the fee guidelines for workers' compensation specific services.

### Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- D90 – Based on further review, no additional allowance is warranted.

### Issues

1. Did the respondent support payment was made for disputed services?
2. What rule is applicable to the reimbursement for the disputed services?

### Findings

1. The requestor is seeking reimbursement of professional medical services in December 2022. The respondent submitted a copy of check number 6202021 dated January 13, 2023 and an explanation of benefits showing a payment of \$119.06 for Code 99213 and \$113.00 for Code 99361-W1 for a total of \$232.06. The requestor wished to continue with MFDR stating "not paid in full."
2. DWC Rule 28 TAC §134.203 (c)(1)(2) states in pertinent parts,

(1) For service categories of Evaluation & Management, General Medicine, Physical

Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) 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 hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007.

The 2022 MAR calculation is  $DWC \text{ Conversion Factor} / Medicare \text{ Conversion Factor} \times CMS \text{ Physician Fee Schedule amount in Dallas, TX}$  or  $62.46/34.6062 \times \$92.65 = \$167.22$

DWC Rule 28 TAC §134.203 (h) states, "When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount."

Based on the above the provider's charge on the medical bill for Code 99213 was \$119.06. This amount was paid. No additional payment due.

DWC Rule 28 TAC §134.204 (e)(4)(A)(i) states, "Case Management Responsibilities by the Treating Doctor is as follows, (4) Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity. Case management services shall be billed and reimbursed as follows: (A) CPT Code 99361. (i) Reimbursement to the treating doctor shall be \$113. Modifier "W1" shall be added."

A review of the submitted medical bill found the provider's charge was \$113.00. This amount was paid. No additional payment 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 requester 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 reimbursement for the disputed services.

### Authorized Signature

\_\_\_\_\_  
Signature

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

November 8, 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).