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
Peak Integrated Healthcare

Respondent Name
AIU Insurance Co.

MFDR Tracking Number
M4-24-0331-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
October 9, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 20, 2023	99203	$216.18	$0.00
June 20, 2023	99080-73	$15.00	$0.00
	Total	$231.18	$0.00

Requestor's Position

"We disagree that original decision should be maintained… This visit should be paid."
Amount in Dispute: $231.18

Respondent's Supplemental Position

"Our bill audit company has determined no further payment is due. The rationale for this determination is found below. DOS: 06/20/2023 - 06/20/2023 Rationale: 99080 denied correctly because worker's compensation work status/report is missing in the medical record."
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 §133.307 sets out the procedures for Medical Fee Dispute Resolution requests.
2. 28 TAC §129.5 set out the guidelines for the filing and reimbursement of Work Status Reports.

Adjustment Reasons

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

- 5283 – Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, provider's contract, or car.
- 90950 – This bill is a reconsideration of a previously reviewed bill; allowance amounts reflect any changes to the previous payment.
- 193, 90563 – Original payment decision is being maintained.

Issues

1. Has the requestor been previously paid for the services in dispute?

2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement in the amount of $231.18 for disputed services rendered on June 20, 2023.

   A review of the submitted medical bills finds that the requestor originally billed the insurance carrier a total amount of $216.18 for the disputed services rendered on June 20, 2023, then upon reconsideration request, the requestor billed a total amount of $231.18.

   A review of the submitted documents finds, per the EOB dated July 17, 2023, that the insurance carrier allowed reimbursement in the amount of $216.18, for CPT code 99203 rendered on June 20, 2023. Payment was issued on July 17, 2023, to Peak Integrated Healthcare via check number 0189943129 in the amount of $216.18, according to the submitted documentation. No payment for CPT code 99080-73 was allowed or issued.

DWC finds that the requestor has been previously paid for CPT code 99203 rendered on June 20, 2023.

2. The requestor is seeking reimbursement in the amount of $216.18 for CPT code 99203 and $15.00 for CPT code 99080-73, for a total amount of $231.18.

   As demonstrated above, CPT code 99203 rendered on the disputed date of service has previously been allowed reimbursement and issued payment for the charge in full. Therefore, DWC finds that the requestor is not entitled to additional reimbursement for CPT code 99203.

   CPT code 99080-73 is described as a Work Status Report which requires that the healthcare provider complete a DWC073 Work Status Report form. A review of the submitted documentation finds no evidence to support the fact that the healthcare provider completed a DWC073 Work Status Report form. Therefore, DWC finds that the requestor is not entitled to reimbursement for disputed CPT code 99080-73.

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 requestor has not established that additional reimbursement is due.

Order

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

Authorized Signature:

Signature	Medical Fee Dispute Resolution Officer	December 5, 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.tas.gov.