



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Peak Integrated  
Healthcare

**Respondent Name**

Hartford Accident & Indemnity Co

**MFDR Tracking Number**

M4-24-1264-01

**Carrier's Austin Representative**

Box Number 47

**DWC Date Received**

February 7, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 3, 2024	99213	\$11.17	\$11.17
January 3, 2024	99080-73	\$0.00	\$0.00
<b>Total</b>		\$11.17	\$11.17

### Requestor's Position

The requestor submitted a copy of their reconsideration dated January 24, 2024, with a handwritten note dated February 7, 2024, that states, "We disagree that this claim should not be PAID IN FULL."

**Amount in Dispute:** \$11.17

### Respondent's Position

"The original bill Was [sic] processed on 1/8/24 under control number 220463617 in the amount of \$189.71. CPT 99213 was paid per fee schedule and 99080 paid at charged."

**Response submitted by:** The Hartford

## 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 fee guidelines for professional medical services.

### Denial Reasons

- 309 – The charge for this procedure exceeds the fee schedule allowance.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 1115 – We find the original review to be accurate and are unable to recommend any additional allowance.

### 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 an outpatient office visit billed under code 99213 which is defined as, "Evaluation and management service code for established patient that requires a moderate level of medical decision-making and a moderate level of complexity in terms of history and examination."

DWC Rule 28 TAC §134.203(a)(5) states, "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

DWC Rule 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.

DWC Rule 28 TAC §134.203(c)(1) states, "...To determine to MAR for professional services, system participants shall apply the Medicare payment policies with minimal modification...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 \$53.68..."

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

$$(DWC \text{ Conversion Factor} \div Medicare \text{ Conversion Factor}) \times Medicare \text{ Payment} = MAR \text{ or,} \\ 67.81/32.7442 \times \$89.76 \text{ (CMS fee schedule for Dallas)} = \$185.88$$

2. The total allowable DWC fee guideline reimbursement is \$185.88. The insurance carrier paid \$174.71. An additional payment of \$11.17 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 established that additional reimbursement is due.

### **Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Hartford Accident & Indemnity Co must remit to Peak Integrated Healthcare \$11.17 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

### **Authorized Signature**

\_\_\_\_\_  
Signature

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

\_\_\_\_\_  
May 16, 2024

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, 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).