TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Peak Integrated Healthcare

Respondent Name
Standard Fire Insurance Company

MFDR Tracking Number
M4-24-2922-01

Carrier's Austin Representative
Box Number 05

DWC Date Received
August 27, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 8, 2024	99213	$185.89	$185.89
	Total	$185.89	$185.89

Requestor's Position

"The above date of service were denied payment due to 'PREAUTH ABSENT.' SEE ATTACHED DD EXAM ALSO THAT CONFIRMS TREATMENT IS FOR COMPENSABLE INJURY. See attached payment for 04/15/2024 OFFICE VISIT for for[*sic*] compensable injury."

Amount in Dispute: $185.89

Respondent's Position

"Attached is a copy of the PLN 11 disputing the extent of injury that has been filed with the DWC as well as a copy of the peer review report that opines further treatment is not supported by ODG Guidelines and therefore requires formal pre-authorization which was not obtained by the provider thus supporting our position."

Response Submitted by: ESIS

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §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) §133.305 sets out the procedures for resolving medical disputes.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 TAC §134.203 sets out the fee guideline for professional medical services.
4. 28 TAC §134.600 sets out the preauthorization requirements for professional medical services.

Denial Reasons

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

- 197 – Precertification/Authorization/Notification/Pre-treatment absent.
- 62 – No proof of pre-auth.
- 2 – This procedure on this date was previously reviewed.

Issues

1. Did the insurance carrier raise the issue of the extent of injury during the bill review process?
2. Is the respondent's denial reason for CPT code 99213 supported?
3. Is the requestor entitled to reimbursement for CPT Code 99213?

Findings

1. This dispute pertains to the non-payment of an office visit, billed under CPT code 99213, and rendered on July 8, 2024. The requestor is seeking reimbursement in the amount of $185.89.

   A review of the insurance carrier's response finds new denial reasons or defenses raised that were not presented to the requestor before the filing of the request for medical fee dispute resolution. 28 TAC §133.307(d)(2)(B) requires that upon receipt of the request for medical fee dispute resolution, the respondent shall provide any missing information not provided by the requestor and known to the respondent, including: a paper copy of all initial and appeal EOBs related to the dispute, as originally submitted to the health care provider… related to the health care in dispute not submitted by the requestor or a statement certifying that the respondent did not receive the health care provider's disputed billing prior to the dispute request.

A review of the submitted information finds insufficient documentation to support that an EOB was presented to the requestor giving notice of the extent of injury, denial reason or defenses raised in the insurance carrier's response to MFDR.

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

The DWC finds that the insurance carrier has raised new denial reasons or defenses. The insurance carrier failed to give notice to the health care provider during the medical bill review process or before the filing of this dispute. Consequently, the DWC concludes that the insurance carrier has waived the right to raise a new denial reason or defense during dispute resolution. Any such new defenses or denial reasons will not be considered in this review.

2. The dispute concerns an evaluation and management service billed under CPT code 99213. The insurance carrier (IC) denied reimbursement citing reason code 197 (described above), lack of preauthorization.

   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 (MDM). When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter."

   28 TAC §134.600(p) sets out the non-emergency professional medical services that require preauthorization. Evaluation and management services are not included in the list of services requiring preauthorization in accordance with 28 TAC §134.600(p). The DWC finds that CPT code 99213 rendered on July 8, 2024, did not require preauthorization therefore, the denial reason is not supported.

3. The requestor seeks reimbursement in the amount of $185.89 for CPT Code 99213 rendered on July 8, 2024.

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

   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…"

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

- The service in question was provided in 2024.
- The 2024 DWC Conversion Factor is 67.81
- The 2024 Medicare Conversion Factor is 32.2875
- A review of the medical bills finds that the disputed service was provided in zip code 75043; the Medicare locality is "Dallas."
- The Medicare Participating amount for CPT code 99213 at this locality is $91.25.
- Using the above formula, the DWC finds the MAR is $185.89.
- The requestor seeks $185.89.
- The respondent paid $0.00.
- Reimbursement of $185.89 is recommended.

The DWC finds that the requestor is entitled to reimbursement for the disputed services. As a result, $185.89, is due to the requestor.

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 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the respondent must remit to the requestor $185.89 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		October 24, 2024
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, 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.