TDI 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
Zurich American Insurance Co

MFDR Tracking Number
M4-25-0081-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
September 11, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 3, 2024	99213	$185.89	$0.00
July 3, 2024	99080-73	$15.00	$0.00
	Total	$200.89	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of request for reconsideration dated August 14, 2024, and September 11, 2024, that states, "The above dates of service were denied full payment stating 'CLAIM NOT COVERED BY PAYER AND CONTRACTOR'. **This is incorrect. WE HAVE RECEIVED PAYMENT FOR ALL OTHER SERVICES IN FULL. --**SEE ATTACHED PMT FOR THE PREVIOUSLY 05/24/204** [*SIC*] **OFFICE VISIT DATE OF SERVICE**."**

Amount in dispute: $200.89

Respondent's Position

"The provider is not entitled to any reimbursement. This is explained on the carrier's EOBs."

Response submitted by: Flahive, Ogden & Latson

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 requirements for professional medical services.
3. 28 TAC §129.5 sets out the documentation and billing requirements of work status reports.

Denial Reasons

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

- 00663-01 – Reimbursement has been calculated based on the State Guidelines.
- 109-1/90147 - Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
- ZK10 – Resolution Manager denials.

Issues

1. Is the insurance carrier's denial supported?
2. What rule is applicable to coding professional medical services?
3. What rule is applicable to work status reports?

Findings

1. The requestor is reimbursement of professional medical services rendered in July of 2024. The insurance carrier denied the claim as not covered by the payer/contractor. Review of the submitted documentation and information known to the Division does not support that Zurich American Insurance Company is not the correct workers' compensation carrier for the disputed services.
2. 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." 28 Texas Administrative Code

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.

Review of the submitted medical bill found the provider submitted code 99213 – "Office or 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. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded."

Review of the submitted "Encounter" note found the documentation supports a straightforward level of decision making. The documentation requirements of disputed code 99213 are not met. No payment is recommended.

3. The requestor seeks payment of code 99080-73 – work status report. DWC Rule TAC §129.5(e) states, "The doctor, delegated physician assistant, or delegated advanced practice registered nurse shall file the Work Status Report:

   (1) after the initial examination of the injured employee, regardless of the injured employee's work status;

   (2) when the injured employee experiences a change in work status or a substantial change in activity restrictions; and

   (3) on the schedule requested by the insurance carrier, its agent, or the employer requesting the report through its insurance carrier, which shall not exceed one report every two weeks and which shall be based upon the doctor's, delegated physician assistant's, or delegated advanced practice registered nurse's scheduled appointments with the injured employee.

Review of the submitted work status report dated July 3, 2024 was not after an initial examination, does not indicate a change in work status or substantial change in activity restrictions, and was not requested by the insurance carrier.

No payment is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

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	October 31, 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. 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.