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
Clinics of North Texas

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-25-0559-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
November 5, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 15, 2024	99204-25	$395.00	$0.00
	Total	$395.00	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of their reconsideration that states, "I have attached the E/M Audit provided by our certified code and auditor showing the MDM level was **Moderate**. **At least 2 elements must be met or exceeded, 2 elements were met**. Problem Score: Moderate, Data Score: Minimal, Risk Score: Moderate. 99204 was billed at the correct level, please reprocess **99204** for payment."

Amount in Dispute: $395.00

Respondent's Position

"Supplemental response will be provided once the bill auding company has finalized their review."

Response submitted by: Gallagher Bassett

Supplemental response submitted November 22, 2024 by Gallagher Bassett

"Our bill audit company stands on their original review."

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 §133.20 sets out the requirements of medical bill submission.

Denial Reasons

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

- 150 – Payment adjusted because the payer deems the information submitted does not support this level of service.
- 193 – original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 56 – Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by the payer.

Issues

1. Is the insurance carrier's denial supported?

Findings

1. The requestor is seeking reimbursement of code 99204 - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

   The requester included information from the encounter that indicates a medically appropriate history was done. The documentation indicates the medical decision making was low based on the procedure performed (simple repair of superficial wound), the ordering of oral medication and administration of a vaccine. None of these treatments are chronic, acute or complicated. The insurance carrier's denial is supported. 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	January 16, 2025 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.