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
Nueva Vida Behavioral Health

Respondent Name
Accident Fund General Insurance Co

MFDR Tracking Number
M4-25-1758-01

Carrier's Austin Representative
Box Number 6

DWC Date Received
April 2, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 10, 2025	99213-25-95	$200.00	$0.00

Requestor's Position

"The consultation for psychotropic medication does not require preauthorization."

Amount in Dispute: $200.00

Respondents' Position

"The Carrier disputes the charges for date of service 01/10/2025 Treatment Code/Services 99213-25-95 Billed Amount $200.00. The service was not certified through utilization review nor was it approved by the adjuster. Subsequently a peer review dated 03/10/2025 supports that this treatment type associated with code 99213-25-95 is not reasonable nor necessary nor is it related to compensable injury."

Response Submitted by: United Heartland

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)§133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.240 sets out the requirements of medical bill processing by insurance carriers
3. The Texas Insurance Code (TIC) §19.2009 sets out the requirements of utilization review prior to adverse medical necessity.
4. 28 TAC §134.600 sets out the requirements of prior authorization.
5. 28 TAC §134.203 sets out the billing and coding requirements for professional medical services.

Denial Reasons

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

- 01 (P12) – The charge for the procedure exceeds the amount indicated in the fee schedule
- OJ (P12) – The services have been rendered by a physician assistant, nurse practitioner, or clinical nurse specialist. The payment is eight-five (85%) percent of the physician's fee schedule value. For assistant-at-surgery services the payment is eight-five (85%) percent of the sixteen (16%) percent physician assistant surgeon allowance.
- 5089 – Service (s) not authorized
- 5347 – Services are unreasonable and unnecessary
- TX P12 – Workers' compensation jurisdictional fee schedule adjustment
- @G (W3) – No additional reimbursement allowed after review of appeal/reconsideration
- 1115 – RECON – We find previous review to be accurate and are unable to recommend any additional allowance
- TX W3 – The Benefit for this service is included in the payment/allowance for another service/procedure that has been performed on the same day

Issues

1. Did the carrier follow the appropriate administrative process to address the assertions made in its response to medical fee dispute?
2. Is the insurance carrier's denial for lack of prior authorization supported?
3. What rule is applicable to reimbursement?

Findings

1. The requestor seeks payment for an office visit, billed under the procedure code 99213-25-95. The respondent states in relevant part, "Subsequently a peer review dated 03/10/2025 supports that this treatment type associated with code 99213-25-95 is not reasonable nor necessary nor is it related to the compensable injury."

   DWC Rule 28 TAC §133.240 (q) states, in relevant part, "When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title ... Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title …, including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor ..."

   The submitted documentation does not support that the insurance carrier followed the appropriate procedures for a retrospective review denial of the disputed services outlined in §19.2003 (b)(31) or §133.240 (q). Therefore, the insurance carrier did not appropriately raise medical necessity for this dispute and this denial reason will not be considered in this review

2. The requestor is seeking reimbursement of code 99213 – "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. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded." The insurance carrier denied the original bill and reconsideration as preauthorization required but not requested.

   DWC Rule §134.600 (p)(7)(10)(12)(14) states in pertinent parts, "Non-emergency health care requiring preauthorization includes: all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized return-to-work rehabilitation program… chronic pain management/interdisciplinary pain rehabilitation… treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier… any treatment for an injury or diagnosis that is not accepted by the insurance carrier under Labor Code §408.0042 and

§126.14 of this title (relating to Treating Doctor Examination to Define the Compensable Injury)."

The evaluation and management code submitted is not within the categories listed above. The insurance carrier's denial for lack of prior authorization is not supported.

3. The requestor submitted a medical bill with Code 99213 used to describe services rendered. Additionally, the place of service used in the submission of the medical bill indicates the services were rendered via telemedicine. DWC Rule §134.203 (b)(1) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits…"

   The requirements for correct coding are.

   - Medically appropriate history and/or examination
   - Low level of medical decision. Medical decision making includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. To qualify for a particular level of medical decision making, two of the three elements for a level of medical decision making must be met or exceeded.
   - Number and complexity of the problems that are addressed at an encounter
   - The amount and/or complexity of data reviewed and analyzed
   - Risk of complications and/or morbidity or mortality of patient management

   Review of the submitted "Progress Note" dated January 10, 2025 found insufficient evidence to support a medical history of the injured workers' condition. An order for medication was made. A referral for therapy was made.

   The position statement from the requestor did not explain or support how the submitted documentation met the requirements of selected code in dispute. The requestor submitted insufficient evidence to support the level of service billed under CPT code 99213. No payment 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 requestor has not established that reimbursement is due.

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

		May 1, 2025
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, please call CompConnection at 1-800-252-7031, option three 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 tres o correo electronico CompConnection@tdi.texas.gov.