

Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

AdventHealth

Respondent Name

Siriuspoint America Insurance

MFDR Tracking Number

M4-25-2630-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

June 23, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 10, 2024	99213	\$548.68	\$0.00

Requester's Position

The requester submitted a document titled "Reconsideration" dated June 11, 2025 that states, "Per the EOB the bill was denied due to the service not being separately payable." Please be advised that other bills on the claim have recently been paid with the same billed CPT 99213 and were paid at UB TX O/P: TX_Physicians FS with EXR \$130.37. Please review this denied bill as the billed CPT 99213 is payable and should be approved for payment.

Amount in Dispute: \$548.68

Respondent's Position

"The denial was due to the facility using a code that is not accepted by Medicare when billed by a facility for Outpatient services. While E/M code, 99213, is a valid CPT code, it is not valid for reimbursement when billed by a facility."

Response Submitted by: CorVel

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 §134.403](#) sets out the billing guidelines for outpatient hospital medical bills.

Denial Reasons

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

- 234 – This procedure is not paid separately
- RB – Not paid under OPPS; no sep payment/packaged svc
- 352 – Network disc not applicable to procedure billed
- W3 – Appeal/Reconsideration

Issues

1. What rule is applicable to the disputed service?
2. Is the requester entitled to reimbursement?

Findings

1. The requester is seeking reimbursement of code 99213 – Office or other outpatient visit for the evaluation and management of an established patient. DWC Rule 28 TAC §134.403 (d) states, "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section..."

DWC Rule 28 TAC §134.403 (b)(3) defines Medicare payment policy as, ""Medicare payment policy" means 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.

The applicable Medicare payment policy is found in the applicable Addenda B for the date of service at www.cms.gov which indicates the following;

- 99213 – Office or other outpatient visit for the evaluation and management of an established patient has a status indicator of "B".

- Addendum D1 at www.cms.gov defines Status Indicator B as – Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type.

2. Based on this review, the insurance carrier's denial as not paid under OPPS is upheld. No payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requester and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to \$0.00 reimbursement for the disputed services

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

July 10, 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 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.