



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

AdventHealth

Respondent Name

Siriuspoint America Insurance

MFDR Tracking Number

M4-25-2661-01

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 17, 2024	99213	\$548.68	\$0.00

Requester's Position

"Per the EOB the bill was originally 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."

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 under OPPS. ...As there is no APC assigned to 99213, payment cannot be made to the facility billing for outpatient services with this code."

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 services.

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/package svc
- 352 – Network disc not applicable to procedure billed
- W3 – Appeal/reconsideration

Issues

1. What rule is applicable to disputed service?

Findings

1. The requester is seeking payment of code 99213 – office or outpatient visit involving established patients and moderate complexity evaluation and management (E/M) service. The insurance carrier denied the service as the service not paid under OPPS.

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 outpatient visit 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 of payment as service not payable 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 additional 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

	Medical Fee Dispute Resolution Officer	July 17, 2025
Signature		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.