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

Requester Name
AdventHealth

Respondent Name
Siriuspoint America Insurance

MFDR Tracking Number
M4-25-2662-01

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 3, 2024	99213	$548.68	$0.00
	Total	$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. 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 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. Request for reconsideration were received by the Carrier on 2/4/25 and 2/21/2025, with the HCP indicating "THIS IS NOT A DUPLICATE. THIS IS A RECONSIDERATION". However, the HCP did not address the reason for denial and the billing code was not corrected. As there is no APC assigned 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 fee guidelines for billing and payment of 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/packaged svc
- 352 – Network disc not applicable to procedure billed
- W3 – Appeal/Reconsideration

Issues

1. What rule is applicable to reimbursement of disputed service?

Findings

1. The requester is seeking reimbursement of code 99213 – Evaluation and management of an established patient in an office or outpatient location for 15 minutes. The insurance carrier denied the claim stating this code is not paid under OPPS.

   DWC Rule 28 TAC §134.403 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

   DWC Rule 28 TAC §134.403 (3) defines "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 of Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

   The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.1. Specifically, Payment Status Indicators and Ambulatory Payment Category (APC).

Review of the Addenda B at www.cms.gov indicates code 99213 had a status indicator of B. This status indicator definition is found in Addenda D1 at www.cms.gov and states, "Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type. Not paid under OPPS."

Review of the submitted medical bill found type of bill in box 4, 131 – Outpatient. Based on the applicable Medicare payment policy the insurance carrier's denial is supported. 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.