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
St Lukes Medical Center

Respondent Name
National Fire Insurance Co of Hartford

MFDR Tracking Number
M4-24-0905-01

Carrier's Austin Representative
Box Number 57

DWC Date Received
December 12, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 28, 2023	320	$0.00	$0.00
June 28, 2023	350	$0.00	$0.00
June 28, 2023	450	$739.70	$0.00
	Total	$739.70	$0.00

Requestor's Position

"This bill is for an ER visit that should have paid per TDI rule 134.403. The carrier originally denied the bill for no medical records. We submitted a reconsideration and they processed and paid $453.30. I then submitted another reconsideration due to an underpayment and the carrier has denied additional reimbursement."

Amount in Dispute: $739.70

Respondent's Position

"Upon receipt of the documentation for this MDR Medical Fee Dispute, Carrier again sent the documentation for review by Conduent Bill Review. Coventry Bill Review Services maintains that no additional allowable is due, as the documentation submitted by the provider does not support CPT 450/99284 visit as per the AMA CPT guidelines. Specifically, Conduent Services indicated that the documentation is better described as code 99281. Therefore, for the reasons noted above, reimbursement is not recommended for the disputed date of service.

Response submitted by: Law Office of Brian J. Judis

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 §134.403 sets out the guidelines for outpatient hospital billing.

Denial Reasons

The insurance carrier reduced/denied the disputed services with the following adjustment codes.

- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 295 – Service cannot be reviewed without report or invoice. Please submit the report/invoice as soon as possible to ensure accurate processing.
- 193 - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3 - Bill is a reconsideration or appeal.
- 802 - Charge for this procedure exceeds the OPPS schedule allowance.
- P12 – Workers' Compensation Jurisdictional fee schedule adjustment.
- 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
- 2008 – Additional payment made on appeal/reconsideration.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 5211 – Nurse audit has resulted in an adjusted reimbursement.

Issues

1. Is the respondent's position supported?
2. What is the rule applicable to reimbursement?

Findings

1. The respondent states in their position statement, "Upon receipt of the documentation for this MDR Medical Fee Dispute, Carrier again sent the documentation for review by Conduent Bill Review." Review of the submitted documentation found insufficient evidence to support a review by Conduent Bill Review was conducted. The respondent's position will not be considered in this review.
2. The requestor is seeking reimbursement of Revenue Code 450 associated with CPT code 99284 -25 rendered on June 28, 2023. The claim was originally denied for lack of information/billing error(s) and this denial was maintained upon reconsideration.

   DWC Rule 28 TAC §134.203 (b)(1) states, "For coding billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply Medicare payment policies, including its coding; billing. Correct coding initiatives (CCI) edits; modifiers…"

   The disputed code 99285 is described as "Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making."

   A review of the submitted medical record indicates a low-level medical decision making. The insurance carrier's denial is supported, and as a result reimbursement 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 requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 additional reimbursement for the disputed service.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 24, 2024 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.