



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Providence Sierra

Respondent Name

Employers Preferred Insurance Co

MFDR Tracking Number

M4-24-1115-01

Carrier's Austin Representative

Box Number 04

DWC Date Received

January 17, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 7, 2023	250	\$0.00	\$0.00
May 7, 2023	80048	\$0.00	\$0.00
May 7, 2023	81001	\$0.00	\$0.00
May 7, 2023	85025	\$0.00	\$0.00
May 7, 2023	72100	\$0.00	\$0.00
May 7, 2023	76870	\$0.00	\$0.00
May 7, 2023	96372	\$0.00	\$0.00
May 7, 2023	99285-25	\$1,006.18	\$0.00
May 7, 2023	J1885	\$0.00	\$0.00
May 7, 2023	93976	\$0.00	\$0.00
Total		\$1006.18	\$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They submitted a copy of their reconsideration dated July 13, 2023, that states, "Providence Hospital East has identified an underpayment for the bill mentioned above. According to our participating provider contract, all outpatient should be reimbursed at 200% of Standard Medicare OPSS pricing for a total expected reimbursement of \$1,202.38. We have received funds totaling \$196.20 with no patient responsibility, thus leaving an underpayment of \$1,006.18."

Amount in Dispute: \$1,006.18

Respondent's Position

"It has been determined this bill was processed correctly and the denial is upheld. Presenting problem's severity does not support the level of ER service billed. Unable to downcode in the state of Texas therefore 99285 is denied."

Response submitted by: Conduent

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 billing guidelines for outpatient hospital services.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 286 – Appeal time limits not met.
- 4915 – The charge for the services represented by the code is included/bundled into the total facility payment and does not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment.
- 5280 – No additional reimbursement allowed after review of appeal/reconsideration.
- 16 – Claim/service lacks information or has submission /billing error(s) which is needed for adjudication.
- 589 – The documentation received does not support the level of service billed. Please adjust the level of service billed or provide additional documentation to support the service billed.
- P12 – Workers; compensation jurisdictional fee schedule adjustment.
- 4552 – Allowance is adjusted due to device credit received from the manufacturer for a replaced medical device.
- 56 – Significant, separately identifiable e/m service rendered.
- 802 – Charge for this procedure exceeds the OPPS schedule allowance.
- 5211 – Nurse audit has resulted in an adjusted reimbursement.

Issues

1. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement of Code 99285-25 rendered on May 7, 2023. While the DWC lists other HCPCS codes, this code is the only amount shown with a disputed amount. The insurance carrier denied the disputed service as submitted documentation does not support the level of service.

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.

- CPT Code 99285 is defined 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."
- The American Medical Association (AMA) CPT Code and Guideline Changes, effective January 1, 2021, can be found at: <https://www.ama-assn.org/system/files/2019-06/cptoffice-prolonged-svs-code-changes.pdf>.

In summary, CPT 99285 documentation requires a medically appropriate history and/or examination. Code selection is based on the level of medical decision making (MDM). Factors to be considered in MDM include the number and complexity of data requiring review and analysis, and risk of complications and/or morbidity or mortality associated with patient management.

- An interactive E&M scoresheet tool is available at: www.novitas-solutions.com/webcenter/portal/MedicareJL/EMScoreSheet
- A review of the submitted medical documentation finds that there is a low level of medical decision making. The medical documentation submitted did not meet AMA criteria for reimbursement of CPT code 99285.
- DWC finds that the insurance carrier's denial reason is supported and as a result, the requestor is not entitled to reimbursement for CPT code 99285 rendered on May 7, 2023.

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 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

Signature

Medical Fee Dispute Resolution Officer

March 18, 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 electrónico CompConnection@tdi.texas.gov.