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
Trans Oakley LLC

Respondent Name
AIU Insurance Co

MFDR Tracking Number
M4-24-1973-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
May 1, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 13, 2023	99284	5,099.20	0.00
May 13, 2023	94761	599.20	0.00
May 13, 2023	72100	2,779.20	0.00
May 13, 2023	A4670	43.20	0.00
May 13, 2023	A4927	34.40	0.00
	Total	$8,555.20	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of their reconsideration letter dated November 23, 2023 that states "Please review this claim for consideration of payment. TotalCare's doctors and staff took great care of your member in a state of medical emergency."

Amount in Dispute: $8,555.20

Respondent's Position

"The Provider contends they are entitled to additional reimbursement at full billed charges for the emergency room visit with ancillary services. The Carrier has reviewed the documentation and contends the Provider has been reimbursed at the correct amount per the applicable Division-

adopted fee schedule. The Carrier reimbursed for the emergency visit (CPT code 99284) and the x-ray diagnostic (CPT code 72100). The remaining billed codes are inclusive to the emergency room visit reimbursement. The supplies are included in the reimbursement, and no separate reimbursement is due. Additionally, the emergency room visit includes reimbursement for the taking of vital statistics, such as pulse oximetry (CPT code 94761) and the documentation does not support that a separate service of oximetry was provided outside the standard vitals assessment. No separate reimbursement is due."

Response submitted by: The Travelers

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 requirements of outpatient hospital claims.
3. 28 TAC §134.203 sets out the billing requirements of professional medical services.

Denial Reasons

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

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 96 – Non-covered charge(s).
- 56 – Significant, separately identifiable e/m service rendered.
- 802 – Charge for this procedure exceeds the OPPS schedule allowance.
- 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.
- 797 – Service not paid under Medicare OPPS.
- W3 – Bill is a reconsideration or appeal.

- 947 – Upheld, no additional allowance has been recommended.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Is the bill type 131 supported?

Findings

1. The requestor is seeking additional payment for services submitted on UB04- CMS1450 as bill type 131. The insurance carrier made a payment based on workers' compensation fee schedule and Medicare OPPS.

   Bill type 131 is defined as.

   - 1 = Hospital
   - 3 = Outpatient
   - 1 = Admit thru discharge (total course of treatment)

   Review of the submitted medical bill found the National Provider Identifier (NPPES) is 1417615006. This NPI indicates a primary taxonomy of 261QE002X – Clinic/Center – Emergency care.

   Based on this review. The submitted bill type is not valid.

   DWC Rule 134.403 (d) states in pertinent part, "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."

   The Division finds the submitted bill type is not valid. Per the rule shown above, no payment is recommended.

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	June 6, 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.