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
Metroplex Adventist Hospital

Respondent Name
Continental Casualty Co

MFDR Tracking Number
M4-25-0066-01

Carrier's Austin Representative
Box Number 57

DWC Date Received
September 9, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 30, 2023	99284/25	$765.97	$765.97
	Total	$765.97	$765.97

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of a document titled "Reconsideration" dated August 26, 2024 that states, "Per EOB received CPT code 99284 disallowed payment. According to CCI edits, code is separately payable due to modifier 25 added o ER visit."

Amount in Dispute: $765.97

Respondent's Position

For the services provided by requestor, CPT codes 99284-25, CPT 90377, CPT 90675 and CPT 90471, the Carrier has rendered payment in the total allowable amount of $5,800.44 as noted on the EORs…"

Response submitted by 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 billing and reimbursement guidelines for outpatient hospital services.

Denial Reasons

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 56 – Significant, separately identifiable E/M service rendered.
- 802 – Charge for this procedure exceeds the OPPS schedule allowance.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 5211 – Nurse Audit has resulted in an adjusted reimbursement.
- 29 – The time limit for filing has expired.
- W3 – Bill is a reconsideration or appeal.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 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.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 4271 – Per TX Labor code Sec. 408.027, providers must submit bills to payors within 95 days of the date of service.

Issues

1. What is the rule applicable to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking payment for outpatient emergency room services. Specifically, code 99284-25, – Emergency department visit. The appended "25" modifier is defined as "Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service." Review of the submitted Emergency Department records support the evaluation and management service was significant and separately identified. The disputed service will be reviewed per applicable fee guidelines.

   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.

   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). The Medicare facility specific amount is calculated when the APC payment rate is multiplied by 60% to determine the labor portion. This amount is multiplied by the facility wage index for the date of service. The non-labor amount is determined when the APC payment rate is multiplied by 40%. The sum of the labor portion multiplied by the facility wage index and the non-labor portion determines the Medicare specific amount.

   - Procedure code 99284 has a status indicator of J2 when the medical bill contains eight or more hours of observation. As the medical bill did not contain observation the criteria for J2 (comprehensive observation) are not met. This code is assigned APC 5024 with a status indicator of V. The OPPS Addendum A rate is $381.61 multiplied by 60% for an unadjusted labor amount of $228.97, in turn multiplied by facility wage index 1.006 for an adjusted labor amount of $230.34.

     The non-labor portion is 40% of the APC rate, or $152.64.

     The sum of the labor and non-labor portions is $382.98.

     The Medicare facility specific amount is $382.98 multiplied by 200% for a MAR of $765.96.

   - Procedure code 90377 has status indicator K, for nonpass-through drugs and biologicals separately paid by APC. This code is assigned APC 9201. The OPPS Addendum A rate is $250.49 multiplied by 60% for an unadjusted labor amount of $150.29, in turn multiplied by facility wage index 1.006 for an adjusted labor amount of $151.19.

     The non-labor portion is 40% of the APC rate, or $100.20.

     The sum of the labor and non-labor portions is $251.39.

     The Medicare facility specific amount is $251.39 multiplied by 10 units = $2,513.90 multiplied by 200% for a MAR of $5,027.80.

   - Procedure code 90675 has status indicator K, for nonpass-through drugs and biologicals

separately paid by APC. This code is assigned APC 9139. The OPPS Addendum A rate is $328.55 multiplied by 60% for an unadjusted labor amount of $197.13, in turn multiplied by facility wage index 1.006 for an adjusted labor amount of $198.31.

The non-labor portion is 40% of the APC rate, or $131.42.

The sum of the labor and non-labor portions is $329.73.

The Medicare facility specific amount is $329.73 multiplied by 200% for a MAR of $659.46.

- Procedure code 90471 has status indicator Q1. This code is assigned APC 5692. The OPPS Addendum A rate is $67.47 multiplied by 60% for an unadjusted labor amount of $40.48, in turn multiplied by facility wage index 1.006 for an adjusted labor amount of $40.72.

  The non-labor portion is 40% of the APC rate, or $26.99.

  The sum of the labor and non-labor portions is $67.71.

  The Medicare facility specific amount is $67.71multiplied by 200% for a MAR of $135.42.

3. The total recommended reimbursement for the disputed services is $6,588.64. The insurance carrier paid $5,800.44. The requestor is seeking $765.97. This amount 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 established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Continental Casualty Co must remit to Metroplex Adventist Hospital $765.97 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		October 25, 2024
Signature	Medical Fee Dispute Resolution Officer	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.