



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Odessa Medical Center

Respondent Name

Berkshire Hathaway Direct Insurance Co.

MFDR Tracking Number

M4-25-0152-01

Carrier's Austin Representative

Box Number 6

DWC Date Received

September 19, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 25, 2023	99285-25	\$7,544.22	\$0.00
September 25, 2023	72125-59	\$900.00	\$0.00
September 25, 2023	71260-59	\$1,614.00	\$0.00
Total		\$10,058.22	\$0.00

Requestor's Position

"...the carrier..., denies to process any of our Facility bills on Facility fee schedule. We have presented them with the UB-04 for the Facility charges on this patient. We are a Free-Standing Emergency room, and we bill for our Facility charges on a UB-04 along with billing for our Physicians charges on a HCFA."

Amount in Dispute: \$10,058.22

Respondent's Position

"Berkshire Hathaway Direct Insurance believes that this bill was paid correctly with the following justification:

Lines 2,3,4,5 belongs to same APC group. Composite APC allowance of \$797.00 is distributed to all lines in the ration of their charge.

Line 1 with CPT code 99285-25 with charge amount \$7544.22 was repriced to \$1006.18 as per TX Fee Schedule rate.

Line 2 with CPT code 72125-59 with charge amount \$900.00 was repriced to \$56.57 because payment is distributed in the ratio of line charge to total charges of the Lines Forming APC Composite Group.

Line 5 with CPT code 71260-59 with charge amount \$1614.00 was repriced to \$101.44 because payment is distributed in the ratio of line charge to total charges of the Lines Forming APC Composite Group.”

Response submitted by: Stone, Loughlin, Swanson

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 fee guidelines for outpatient hospital services.
3. [28 TAC §134.203](#) sets out the Medical Fee Guideline for Professional Service.
4. [28 TAC §133.10](#) sets out the requirements of medical bill submission forms.
5. [28 TAC §133.20](#) sets out the billing requirements for medical bills.

Adjustment Reasons

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

- P12 – Workers’ compensation jurisdictional fee schedule adjustment.
- 630 – This service is packaged with other services performed on the same date and reimbursement is based on a single composite APC rate.
- 370 – This hospital outpatient allowance was calculated according to the APC rate plus a markup.
- 350 & W3 – This bill has been identified as a request for reconsideration or appeal.

Issues

1. Did the requestor support submission of the medical bill in accordance with the applicable DWC Statutes and Rules?

Findings

1. This dispute involves payment for outpatient facility services performed in a free-standing emergency clinic.

The requestor seeks additional reimbursement on a medical bill submitted on a UB04 with bill type 131. In its position statement submitted with this medical fee dispute resolution (MFDR) request, the requestor states that they are a "Free-Standing Emergency room."

28 TAC §134.203(b)(1), which applies to the services in dispute, states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

A review of the submitted documents finds that the requestor billed for the disputed services on medical billing form UB-04, used to bill for medical facility services. The requestor populated box 4 of the billing form with Type of Bill code 131. Type of Bill 131 is defined by the Centers for Medicare and Medicaid Services (CMS) as Hospital Outpatient, admit through discharge.

A review of the submitted medical bill finds that box 56 is populated with NPI number 1194290106. The NPPES website at www.cms.hhs.gov indicates this NPI number is identified as 207P00000X – Emergency Medicine and Taxonomy 193400000X – Single Specialty Group. Taxonomy code 207P00000X, the requestor's primary taxonomy code, is described as an emergency physician or physician group who focuses on the immediate decision making and action necessary to prevent death or any further disability both in the pre-hospital setting and in the emergency department.

According to the NPPES website, the requesting facility is not licensed or identified as an acute care outpatient hospital and therefore does not meet the criteria of Bill Type 131.

DWC Rule 28 TAC §133.20 (c) states in pertinent part, "A health care provider must include correct billing codes from the applicable division fee guidelines in effect on the date or dates of service when submitting medical bills."

DWC Rule 28 TAC §133.10 sets out that the UB04 medical bill submission form is to be submitted for the billing of medical institution/facility services.

Based on this review, DWC finds the bill type 131 is not valid for the requestor's medical bill as the reported NPI is not associated with an Outpatient Hospital. No additional 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 requestor 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 additional reimbursement in the amount of \$0.00 for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

November 8, 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, 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.