



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Deerfield Plains, LLC

Respondent Name

Deep East Texas Self Insurance Fund

MFDR Tracking Number

M4-25-1622-01

Carrier's Austin Representative

Box Number 44

DWC Date Received

March 17, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 2, 2024	99284-25	\$1600.00	\$0.00
May 2, 2024	73030-TC	\$179.00	\$0.00
Total		\$1,779.00	\$0.00

Requestor's Position

"We are submitting this request for a reassessment of the reimbursement for services provided to the patient at Deerfield Plains, LLC. The current payment does not align with the fair and reasonable standard outlined in Texas Administrative Code §134.1."

Amount in Dispute: \$1,779.00

Respondent's Position

"The provider believes additional reimbursement should be awarded for several CPT Codes. However, the fee guidelines do not support additional reimbursement. The bill was processed per the Texas Fee Guidelines. Also, some of these services were bundled into the APC rate."

Response submitted by: White Espey PLLC

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 §133.10](#) sets out the requirements of medical bill submission forms.
3. [28 TAC §133.20](#) sets out the billing requirements for medical bills.

Denial Reasons

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

- 176 – Modifier 27 / TX represents the technical component of services performed.
- 222 – Charge exceeds Fee Schedule allowance.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

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

Findings

1. The requestor seeks additional reimbursement on a medical bill submitted on a UB04 with bill type 131 for date of service May 2, 2024. Also included in the documentation was a CMS 1500 claim form. No explanation of benefits was found regarding these charges. The charge for 99284 -25 for \$5462.00 and 73030 -26 RT 59 for \$1613.00 will not be considered in this review.

A review of box 56 of submitted bill found NPI number 1275110108. The NPPES website at www.cms.hhs.gov indicates Taxonomy 261Q30002X – Clinic/Center - Emergency Medicine.

Bill type 131 is defined by CMS as Hospital Outpatient admit through discharge.

DWC Rule 28 TAC §133.20 (c) states in pertinent parts, A health care provider must include correct billing codes... when submitting medical bills.

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 for an Outpatient Hospital. No additional reimbursement is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

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

_____	_____	<u>April 16, 2025</u>
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 electrónico CompConnection@tdi.texas.gov.