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
National Fire Insurance Co of Hartford

MFDR Tracking Number
M4-25-1814-01

Carrier's Austin Representative
Box Number 57

DWC Date Received
April 7, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 4, 2025	96372	$139.50	$0.00
January 4. 2025	99284	$834.68	$0.00
	Total	$974.18	$0.00

Requestor's Position

The requestor did not submit a position statement but rather a document titled "Reconsideration" dated March 18, 2025 that states, "The billed charges were not paid correctly per TX work comp guidelines. According to TX Workers Compensation Fee Schedule the expected reimbursement for DOS 1/4/2025 is $980.06. Previous payment received totaled $6.00. We ask that you reprocess and remit payment for remaining balance due."

Amount in Dispute: $974.18

Respondent's Position

"After a review by Stratacare's Clinical Validation team of billing attachments, the submitted billing documents fail to support the level of services billed. CPT 99284 complexity of level 4 is not support in this claim where a 23-year-old (redacted) after jerking motion. ...96372 is not separately billable per NCCI. ...These drug administration services shall not be reported by

providers/suppliers for services provided in a facility setting such as a hospital outpatient department or emergency department."

Response Submitted by: Law Office of Brian J. Judis

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §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

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- Note: 5211 – per nurse audit 96372 code denied as not separately reimbursable.
- P5 Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.
- 942 – Separate reimbursement for this line item is denied. The clinical information and detail submitted on the procedures rendered indicates that separate reimbursement for this line would be inappropriate or has been included in the value of the procedure performed.
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 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.

Issues

1. Did the requestor support a position statement that details how the medical record supports the submitted code?

2. Does a National Correct Coding Initiative (NCCI) edit exist?

3. Is additional reimbursement due?

Findings

1. The requestor is seeking reimbursement of outpatient emergency room services rendered on January 4, 2025. The submitted medical bill contained the following.

    - 99284 **-** Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making

    - 96372 - Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular

    The insurance carrier denied the charge for the emergency department visit as charge exceeds the OPPS schedule allowance. DWC Rule 28 TAC §134.403 (d) states, "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." DWC Rule 28 TAC §134.403 (b) (3) defines Medicare payment policy as, ""Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

    The requirements of code 99284 indicate a "moderate level of medical decision making". Review of the submitted medical record and position statement did not contain sufficient information to support the level of medical decision making as no testing was rendered and while medication was administered and prescriptions ordered, the injured worker was discharged without complication.

2. The insurance carrier denied code 96372 per the NCCI coding edits. Review of the applicable Medicare CCI Guidelines, procedure code 96732 has an unbundle relationship with code 99284. The insurance carrier's denial is supported.

3. The DWC finds after reviewing all available documentation the requestor did not provide a position statement supported by the submitted medical records to support the payment of the codes in dispute. No payment 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 $0.00 reimbursement for the disputed services

Authorized Signature

	Medical Fee Dispute Resolution Officer	June 10, 2025
Signature		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 three 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 tres o correo electronico CompConnection@tdi.texas.gov.