



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

University Medical Center

**Respondent Name**

Everest National Insurance Co

**MFDR Tracking Number**

M4-24-2426-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

July 1, 2024

### Summary of Findings

| Dates of Service     | Disputed Services | Amount in Dispute | Amount Due |
|----------------------|-------------------|-------------------|------------|
| August 21 – 28, 2023 | 0120              | \$25,613.29       | \$0.00     |
| <b>Total</b>         |                   | \$25,613.29       | \$0.00     |

### Requestor's Position

"This bill is for a 7-day inpatient stay that should pay per TDI rule 134.404. We submitted an original bill to the carrier, and they have denied stating we are unable to process the bill with the current DRG. We submitted an appeal with a detailed explanation on why this DRG is the correct and payable code and the have denied the appeal. ...The DRG code of 983 has a payment rate of \$17911.39 x 143%=\$25613.29 and this is the amount of our dispute."

**Amount in Dispute:** \$25,613.29

### Respondent's Position

"Our supplemental response for the above referenced medical fee dispute resolution is as follows: the bills in question were escalated and a review completed. Our bill audit company has determined no further payment is due... ...We are upholding our previous denial for reason of the DRG description is not matching all the areas."

**Response submitted by:** Gallagher Bassett

## 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 §134.404](#) sets out the billing procedures for inpatient hospital services.

### Denial Reasons

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

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- - Payment made per Medicare's IPPS methodology, with the applicable state markup.
- CV: We are unable to process this bill with the current DRG. Please resubmit with the correct/valid DRG.

### Issues

1. Is the insurance carrier's denial?

### **Findings**

1. The requestor is seeking payment of an inpatient hospital stay from August 2023. The insurance carrier denied the claim stating the claim had a billing error. On the explanation of benefits the "note" indicated a correct/valid DRG was needed.

DWC Rule 28 TAC §134.404 (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 with any additions or exceptions specified in this section."

Review of the submitted documentation and ICD-10-CM/PCS MS-DRG v40.0 Appendix B at [www.cms.gov](http://www.cms.gov), the insurance carrier's denial is supported. Reimbursement is not 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**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

September 25, 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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).