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
Methodist Health System

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-25-0145-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
September 17, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 4 – 8, 2024	Emergency visit	$13,067.20	$0.00
	Total	$13,067.20	$0.00

Requestor's Position

"This bill denied for lacking the provider license number which was added to the UB on the reconsideration. Appeal also denied."

Amount in Dispute: $13,067.20

Respondent's Position

"Attached is a copy of the PLN 11 disputing the extent of injury that has been filed with the DWC as well as a copy of the peer review report that supports our position that the treatment is not related to the accepted compensable injury."

Response submitted by: ESIS

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 requirements for medical bills.

Denial Reasons

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

- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 2. A technical Bill Review (TBR) has been performed.
- 3. Bill is denied, invalid / missing healthcare provider license number. Please re-submit with appropriate license number for review.

Issues

1. Did the respondent raise a new issue?
2. Did requestor submit the disputed medical in compliance with DWC rules?

Findings

1. Review of the insurance carrier's response finds new denial reasons or defenses raised that were not presented to the requestor before the filing of the request for medical fee dispute resolution.

   A review of the submitted information finds insufficient documentation to support that an EOB was presented to the health care provider, giving notice of the extent of injury / compensability denial reason or defense raised in the insurance carrier's response to MFDR.

   Rule §133.307(d)(2)(F) requires that: The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

2. The requestor is seeking reimbursement of a medical bill submitted with bill type (131) "Outpatient hospital." Review of the submitted medical record found the following.
   - Informed patient of plan to admit patient to the hospital for further care and management.

- MD Hospitalist who accepts admission and will be assuming care for this patient.
- Admit Date and Time: 3/4/2024 12:48 pm

Based on this review, the services rendered to the injured employee for dates of service March 4, 2024 through March 8, 2024 were for an inpatient hospital admission.

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."

The Division finds the submitted medical bill contained an incorrect bill type based on the submitted medical records, no 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

Signature	Medical Fee Dispute Resolution Officer	November 13, 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, 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.