



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Texas Health Huguley

Respondent Name

Everest Premier Insurance Co

MFDR Tracking Number

M4-25-0499-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

October 28, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 27, 2023	DRG914	\$11,043.19	\$0.00
Total		11,043.19	\$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a document titled "Reconsideration" dated October 21, 2024 that states, "Per EOB, disallowed reimbursement due to claim/service lacks information which, is needed for adjudication and OP report/medical records are required for review and resubmit. Be advised medical documentation for services has been provided to adjudicate services."

Supplemental response dated December 19, 2024

"I do not show payment received."

Amount in Dispute: \$11,043.19

Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed. We will provide a supplemental response once the bill auditing company has finalized their review."

Response Submitted by: Gallagher Bassett

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 requirements and fee guidelines for inpatient hospital services.

Denial Reasons

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

- 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. (4896)
- CV: Documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge. Please submit documentation to substantiate charges (5242)
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is the insurance carrier's denial supported?

Findings

1. The requestor is seeking payment of hospital services rendered November of 2023. The insurance carrier denied the charges for lack of documentation to support the submitted charges. Review of the submitted "Discharge Summary" indicates date of admission: 11/27/2023 and discharge date 11/27/2023.

DWC Rule 134.403(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 CMS Medicare Benefit Policy Manual Chapter 1 - Inpatient Hospital Services at www.cms.gov states,

1 – Definition of Inpatient Hospital Services - Inpatient hospital services are defined in Title XVIII of the Social Security Act (the Act) and in the regulations (42 CFR 409.10): A. *Subject to the conditions, limitations, and exceptions set forth in this subpart, the term "inpatient hospital or inpatient CAH services" means the following services furnished to an inpatient of a participating hospital or of a participating CAH or, in the case of emergency services or services in foreign hospitals, to an inpatient of a qualified hospital:*

1. *Bed and board.*
2. *Nursing services and other related services.*
3. *Use of hospital or CAH facilities.*
4. *Medical social services.*
5. *Drugs, biologicals, supplies, appliances, and equipment.*
6. *Certain other diagnostic or therapeutic services.*
7. *Medical or surgical services provided by certain interns or residents-intraining.*
8. *Transportation services, including transport by ambulance.*

As the submitted documentation does not support the charge for room and board, the insurance carrier's denial for lack of documentation is supported. 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

_____	_____	February 4, 2025
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 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 electrónico CompConnection@tdi.texas.gov.