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

Requester Name
University Medical Center

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-25-1944-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
April 22, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 24 – 26, 2024	EC/Outpatient visit	$12,414.90	$0.00
	Total	$12,414.90	$0.00

Requester's Position

The requester did not submit a position statement with this request for MFDR.

Amount in Dispute: $12,414.90

Respondent's Position

"Texas Mutual has reviewed the DWC-60 submitted by UNIVERSITY MED CTR. The DWC60 was received prematurely as the provider submitted a subsequent billing which is currently pending finalization (invoice #000018596375) explanation of benefits will be provided once available."

Response Submitted by: Texas Mutual

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 guidelines for outpatient services.

3. 28 TAC §134.404 sets out the billing guidelines for inpatient services.

Denial Reasons

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

- 892,225: Medical records show patient was admitted to the hospital on 9/23/24. Service should be billed as inpatient. Please correct billing and resubmit for reconsideration.
- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- CAC-W3/350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- DC4 – No additional reimbursement allowed after reconsideration.
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 892 – Denied in accordance with DWC Rules and/or medical fee guideline including current CPT code descriptions/instructions.

Issues

1. Is the insurance carrier's denial supported.

Findings

1. The requester is seeking reimbursement of medical services rendered in a health care facility. Review of the submitted medical bill (UB-04 CMS-1450) indicates the medical bill was submitted as an outpatient (131 indicated in box 4) type of bill. Review of the submitted medical record indicates.

    - ED Discharge Summary – "Transport Reason: Admission to hospital

    - Emergency Center Physician Documentation – Admit to hospital

        - Notify Provider/Primary Team of PT admit

- Medical Record / Orders – IP Admit Date/Time 09/24/24 5:20:00 CDT, Level of Care Floor/Med Surg.

Based on this review, the insurance carriers denial for billing error is supported. No additional payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requester and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to $0.00 reimbursement for the disputed services

Authorized Signature

	Medical Fee Dispute Resolution Officer	July 9, 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.