



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Methodist Health System

**Respondent Name**

Texas Municipal League Intergovernmental Risk Pool

**MFDR Tracking Number**

M4-25-2148-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

May 7, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 16 – 29, 2024	Emergency visit	\$5,505.64	\$0.00

### Requestor's Position

"This bill and appeal were incorrectly denied. Payer states that this should be an inpatient bill, but the date range covers the initial emergency visit, labs and therapy."

**Amount in Dispute:** \$5,505.64

### Respondent's Position

"The provider failed to properly bill the services. The services were billed as outpatient when the services were for inpatient. Unless and until the provider properly bills the services, it is not entitled to payment."

**Response Submitted by:** Flahive, Ogden & Latson

## 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 coding guidelines for outpatient hospital services.

### Denial Reasons

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

- 375 – Please see special \*NOTE\* below.
- 5 – The procedure code/type of bill is inconsistent with the place of service.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- 938 – Either the type of bill is missing and required for these services, or this is the wrong type of bill for these services.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- Note: This is the wrong type of bill for these services.

### Issues

1. Did the requestor provide any evidence to support the claim that the reported services were exclusively provided as outpatient services?

### Findings

1. The requestor is seeking reimbursement of services rendered from May 16, 2024 through May 29, 2024 at Methodist Dallas Medical. The submitted medical bill indicated "Type of Bill" 0131 outpatient stay.

Review of the submitted medical records (Care Timeline) found on page 188 indicates the following.

- "ED to Hosp-Admission (Discharged) on 5/16/2024."
- 05/17 – Admitted from ED (Observation)
- 05/29 – Discharged

Based on this review, DWC finds the patient was admitted through the emergency department of the hospital. The patient was discharged from ED on May 16, 2024 and admitted into the hospital (inpatient) on May 17, 2024 where they remained until discharged on May 29, 2024.

The Medicare Claims Processing Manual at [Medicare Benefit Policy Manual](#), Section 10 states, *"An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services (see §10.2 below). Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will require hospital care that is expected to span at least two midnights and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight."* As the injured worker was admitted as inpatient, the insurance carrier's denials are 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**

_____	Medical Fee Dispute Resolution Officer	May 30 , 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](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 three 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 tres o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).