TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MEMORIAL HERMANN HEALTHCARE SYSTEM

Respondent Name
LIBERTY MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-18-0546-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
October 31, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not issued an Explanation of Benefits."

Amount in Dispute: $40,244.14

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill has been reviewed and we are unable to issue reimbursement as charges are for a condition that Is not related to the compensable injury."

Response Submitted by: Liberty Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
October 31, 2016 to November 8, 2016	Inpatient Hospital Services	$40,244.14	$40,244.14

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.404 sets out the acute care hospital fee guideline for inpatient services.
3. The insurance carrier did not issue any explanations of benefits or present any documentation to support that the health care provider had been given notice of any denial reasons or defenses prior to the filing of the request for medical fee dispute resolution. Per Rule §133.307(d)(2)(F) 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.

Issues

1. Did the insurance carrier issue any denials or raise any defenses prior to the filing of the request for MFDR?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to additional payment?

Findings

1. Review of the submitted documentation finds that the insurance carrier did not issue any explanations of benefits or present documentation to support notice to the health care provider of any defenses to payment of the disputed services prior to the filing of the request for medical fee dispute resolution.

   28 Texas Administrative Code §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.

   The respondent is limited at Medical Fee Dispute Resolution to arguing those denial reasons the carrier has enumerated on the explanations of benefits. Failure to raise specific denial reasons during medical bill processing or reconsideration are grounds for the division to find a waiver of defenses at MFDR. Any newly raised denial reasons or defenses shall not be considered in this review.

   As no information was presented to support the insurance carrier had provided to the requestor any denial reasons or defenses regarding the disputed services prior to the filing of the MFDR request, the division finds the respondent has waived any such defenses. The disputed services will therefore be reviewed for payment according to applicable division rules and fee guidelines.

2. This dispute regards Inpatient hospital facility services provided to an injured employee with payment subject to 28 Texas Administrative Code §134.404(f), which requires that the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount (including outlier payments) applying the effective Medicare Inpatient Prospective Payment System (IPPS) formulas and factors, published annually in the Federal Register, with modifications as set forth in the rule. Medicare IPPS formulas and factors are available from http://www.cms.gov.

   Review of the submitted information finds that separate reimbursement for implantables was not requested. Rule §134.404(f)(1)(A) requires that reimbursement for these disputed services be calculated by multiplying the Medicare facility specific amount by 143 percent.

   Review of the submitted medical bill and supporting documentation finds that the DRG code assigned to the disputed services is 856. The services were provided at MHHS Greater Heights Hospital in Houston, Texas. Based on the submitted DRG code, the service location, and bill-specific information, the division finds that the Medicare facility specific amount is $30,252.59. This amount multiplied by 143% results in a MAR of $43,261.20.

3. The total recommended payment for the services in dispute is $43,261.20. The insurance carrier has paid $0.00. The requestor is seeking $40,244.14. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the available evidence presented by the requestor and respondent at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $40,244.14.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $40,244.14, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	January 12, 2018
Signature	Medical Fee Dispute Resolution Officer	Date
	Martha Luévano	January 12, 2018
Signature	Director of Medical Fee Dispute Resolution	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (form DWC045M) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.