TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
CHRISTUS SPOHN SHORELINE HOSPITAL

Respondent Name
LIBERTY MUTUAL FIRE INSURANCE COMPANY

MFDR Tracking Number
M4-18-4040-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
June 20, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This surgery was pre-authorized. . . . Liberty Mutual has denied this claim stating the coding is not correct. . . . The coding is correct according to coding guidelines and is reflective of the documentation of the treating physician."

Amount in Dispute: $80,871.51

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Liberty Mutual believes that Christus Spohn Shoreline Hospital has been appropriately reimbursed for services rendered . . . for the 11/29/2016 to 12/2/2016 date(s) of service."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 29, 2016 to December 2, 2016	Inpatient Hospital Services	$80,871.51	$0.00

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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - X045 – DRG CODE CONSIDERED INVALID BASED ON ONE OR MORE OF THE FOLLOWING. 1. INCORRECT DRG VERSION PER STATE FEE SCHEDULE GUIDELINES. 2. INCORRECT ASSIGNMENT OF ONE OR MORE ICD-9 DIAGNOSIS OR ICD-9 PROCEDURE CODES. 3. DOCUMENTATION FROM MEDICAL RECORDS DOES NOT SUPPORT CODE ASSIGNMENT OF BILLED DRG. PLEASE REVIEW AND SUBMIT CORRECTED BILLING FORM WITH REVISED DRG AND, OR DOCUMENTATION SUPPORTING DRG ASSIGNMENT.
   - 193 – DRG CODE CONSIDERED INVALID BASED ON ONE OR MORE OF THE FOLLOWING. 1. INCORRECT DRG VERSION PER STATE FEE SCHEDULE G
   - W3 – DRG CODE CONSIDERED INVALID BASED ON ONE OR MORE

Issues

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states:

> Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.
>
> (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

The dates of service in dispute are from November 29, 2016 to December 2, 2016. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on June 20, 2018. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds the disputed services do not involve issues identified in §133.307(c)(1)(B). The division concludes the requestor has failed to timely file this dispute with the division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the information submitted by the parties, in accordance with the provisions of Texas Labor Code §413.031, the division determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	August 10, 2018
Signature	Medical Fee Dispute Resolution Officer	Date
	Martha Luévano	August 10, 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.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.