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
METSL, LLC

Respondent Name
Ohio Security Insurance Co

MFDR Tracking Number
M4-20-0795-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
December 2, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per EOB received bill for DOS 7/22/19 denied for no preauthorization. Please not that authorization was obtained for treatment under Authorization# 15845254..."

Amount in Dispute: $76,415.05

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "DRG 473 is the supported DRG per the medical records."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
July 22 – 23, 2019	Inpatient hospital services	$76,415.05	$19,953.36

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 reduced payment for the disputed services with the following claim adjustment codes:
   - 5917 – Pre-authorization was required, but not requested for this service per DWC Rule 134.600

Issues

1. Is the insurance carrier's position supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to additional payment?

Findings

1. The insurance carrier states in their response, "473 is the supported DRG per the medical records." Review of the submitted medical records found no indication of any complication or comorbidity which was reported by the health care provider's medical bill and DRG 472. The insurance carrier's position is supported. This information will be used in review of the disputed claim.
2. The insurance carrier denied the disputed inpatient hospital service based on lack of preauthorization. The requestor included prior authorization from Coventry dated June 12, 2019 for Anterior Cervical Discectomy and Fusion with a reference number of 15845254. The carrier's denial is not supported. The fee will be calculated based on applicable fee guideline.

   28 Texas Administrative Code §134.404(f) states the reimbursement will be the Medicare facility specific amount as published annually in the Federal Register, with modifications set forth in the rules.

   Medicare IPPS formulas and factors are available from the Centers for Medicare and Medicaid Services at http://www.cms.gov.

   28 TAC §134.404(f)(1)(A) requires the Medicare facility specific amount be multiplied by 143% as separate reimbursement for implants was not requested.

   Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 473. The service location is Southlake, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $13,953.40. This amount multiplied by 143% results in a MAR of $19,953.36.
3. The total recommended payment for the services in dispute is $19,953.36. This amount is recommended.

Conclusion

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 $19,953.36.

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 $19,953.36, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

	Peggy Miller	January 17, 2020
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 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC, 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 TAC §141.1(d).

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