TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
MMHS

Respondent Name
Liberty Insurance Corp

MFDR Tracking Number
M4-23-0489-01

Carrier's Austin Representative
Box Number 1

DWC Date Received
October 18, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 14 – 16, 2022	Inpatient Stay	$55,837.00	$22,886.28
	Total	$55,837.00	$22,886.28

Requestor's Position

"We have provided all the documentation the carrier has requested multiple times and has not overturned their denial."

Amount in Dispute: $55,837.00

Respondent's Position

"The provider did not support how there was an increase in the consumption of service for Acute posthemorrhagic anemia as there is no documentation to support what treatment was provided to resolve the diagnosis other than standard care given to every patient admitted for surgery."

Response Submitted by: Liberty Mutual

Findings and Decision

Authority

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

Statutes and Rules

1. 28 TAC §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.

Denial Reasons

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

- 589 – The documentation received does not support the level of service billed. Please adjust the level of service billed or provide additional documentation to support the service billed

Issues

1. Is the respondent's denial 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 requestor is seeking payment for an inpatient hospital stay in March 2022. The insurance carrier denied the claim stating the documentation does not support the level of service.

   Review of the submitted medical record found the injured worker was diagnosed with (redacted).

   DWC Rule 134.404 (d) states, "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided."

   DWC Rule 134.404 (3) states "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

   Review of the CMS coding at MS-DRG Classifications and Software | CMS, manual found the reported injury diagnosis and history diagnoses do support the reported DRG 481: Hip and

femur procedures except major joint with complications or comorbidity (CC). The carrier's denial is not supported.

2. This dispute regards inpatient hospital facility services with payment subject to 28 TAC §134.404(f), requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount (including outlier payments) applying Medicare Inpatient Prospective Payment System (IPPS) formulas and factors, 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.

   The division calculates the Medicare facility specific amount using Medicare's *Inpatient PPS Web Pricer* as a tool to efficiently identify and apply IPPS formulas and factors. This software is freely available from https://webpricer.cms.gov/#/pricer/ipps.

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

   Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 481. The service location is Sugarland Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $16,004.39. This amount multiplied by 143% results in a MAR of $22,886.28.

3. The total recommended payment for the services in dispute is $22,886.28. This amount 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 requester has established that additional reimbursement {of $22,886.28 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Liberty Insurance Corp must remit to MHHS $22,886.28 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		December 13, 2022
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 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 3 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 3 o correo electronico CompConnection@tdi.texas.gov.