TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

# Medical Fee Dispute Resolution Findings and Decision

## General Information

**Requestor Name**
Crescent Medical Center

**Respondent Name**
Travelers Indemnity Co

**MFDR Tracking Number**
M4-23-1019-01

**Carrier's Austin Representative**
Box Number 5

**DWC Date Received**
January 5, 2023

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| May 22 - 25, 2022 | Implants Rev 0278 | $0.00 | $0.00 |
| May 22 – 25, 2022 | DRG 454 | $43,371.58 | $0.00 |
| | **Total** | $43,371.58 | $0.00 |

## Requestor's Position

The requestor did not submit a position statement with this request for MFDR.

**Amount in Dispute:** $43,371.58

## Respondent's Position

"As the submission did not involve any complications comorbidities, the admission does not meet the criteria for DRG 454. The documentation does not support the use of this DRG."

Response submitted by: Travelers

## 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 TAC §134.404 sets out the billing requirements for inpatient hospital stays.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 4896 – Payment made per Medicare's IPPS methodology. With the applicable state markup
- 5443 – Submitted documentation/medical record and/or diagnosis and procedure codes assigned by the provider do not support the billed DRG. The information grouped to a different DRG than what was billed. Please rebill with the corrected DRG code
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration
- 13 – An additional allowance has been recommended for implants/prosthetics/DME/Suppliers

Issues

1. Did the requestor meet the documentation policy of applicable DWC Rule?

Findings

1. The requestor is seeking reimbursement for an inpatient hospital stay in May of 2022. The insurance carrier denied DRG 454 as the submitted documentation does not support the billed DRG.

   DWC Rule §134.404 (d) states in pertinent part, 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.

The submitted DRG is defined as 454 – Combined anterior and posterior spina fusion with CC.

The ICD-10 CM/PCS MS-DRG v37 Definitions Manual at ICD-10-CM/PCS MS-DRG v37.0 Definitions Manual (cms.gov) found CC means either a complication or commodity or major complication or comorbidity.

Review of the Appendix C, Complications or Comorbidities Part 1 at ICD-10-CM/PCS MS-DRG v37.0 Definitions Manual (cms.gov) found the primary diagnosis submitted on the medical bill does not qualify as complication or comorbidity.

The submitted medical records did not indicate any other conditions that would qualify as a complication or comorbidity.

The insurance carrier's denial is supported. No additional 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 requester has not established that additional reimbursement is due.

## Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | February 24, 2023<br>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.