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
Methodist Dallas Medical Center

Respondent Name
LM Insurance Corp

MFDR Tracking Number
M4-23-3210-01

Carrier's Austin Representative
Box Number 01

DWC Date Received
August 16, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 9 -11, 2022	Inpatient	$22,481.91	$0.00
	Total	$22,481.91	$0.00

Requestor's Position

"Per denial attached, the carrier has requested "Valid DRG and/or Medicare number required for review. Please re-submit bill with proper information for further processing." Original bill and medical records are show which provide the Medicare in box 51 of the UB and valid medical documentation to meet the standards for payment on an inpatient bill per TX fee basis guidelines. Please provide relief for the following appeal.

Amount in Dispute: $22,481.91

Respondent's Position

"With Clinical Coding Expert (CCE) software usage by the carrier, the diagnosis that is triggering the assignment of CC DRG is Z68.42, Body mass index of 45.0-49.9. The carrier does not argue that the injured worker has increased BMI, a chronic diagnosis. The carrier argues the payment of this diagnosis as a CC when no supporting documentation was received to show how there was

an increase level of care, increased consumption of service, or how this chronic disease became a significant acute manifestation of the chronic disease during the admission. The DC summary does not mention any treatment being provided for this diagnosis. The diagnosis was not mentioned in the DC summary."

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 TAC §134.404 sets out the billing and coding guidelines for inpatient hospital services.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) 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.
- 185 – Valid DRG and/or Medicare number required for review, Please re-submit bill with proper information for further processing.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement of inpatient hospital services rendered to an injured worker on dates of service November 9 – 11, 2022. The insurance carrier denied the claim as invalid DRG and level of service not supported.

   Review of the submitted medical bill found the submitted DRG Code was "513" – Hand or wrist procedures, except major thumb or joint procedures with CC/MCC.

Review of the "Triage Notes" dated November 9, 2022 lists diagnosis related to (redacted). Review of the admission, operative report and discharge summary does not mention any of these diagnosis or any treatment required during the inpatient stay.

DWC Rule 28 TAC §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…

Based on the above, the requestor's use of DRG 513, Hand or wrist procedures, except major thumb or joint procedures with CC/MCC is not supported by the medical records submitted with this request for MFDR.

The insurance carrier's denial is supported. No 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 reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 19, 2023 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.