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
Texas Health Fort Worth

Respondent Name
Liberty Mutual Fire Insurance Co

MFDR Tracking Number
M4-23-3311-01

Carrier's Austin Representative
Box Number 60

DWC Date Received
August 24, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 19 – 22, 2023	0111	Left blank	$0.00
March 19 – 22, 2023	0250	Left blank	$0.00
March 19 – 22, 2023	0258	Left blank	$0.00
March 19 – 22, 2023	0272	Left blank	$0.00
March 19 – 22, 2023	0278	Left blank	$0.00
March 19 – 22, 2023	0300	Left blank	$0.00
March 19 – 22, 2023	0301	Left blank	$0.00
March 19 – 22, 2023	0305	Left blank	$0.00
March 19 – 22, 2023	0320	Left blank	$0.00
March 19 – 22, 2023	0350	Left blank	$0.00
March 19 – 22, 2023	0351	Left blank	$0.00
March 19 – 22, 2023	0352	Left blank	$0.00
March 19 – 22, 2023	0360	Left blank	$0.00
March 19 – 22, 2023	0370	Left blank	$0.00
March 19 – 22, 2023	0420	Left blank	$0.00
March 19 – 22, 2023	0424	Left blank	$0.00
March 19 – 22, 2023	0450	Left blank	$0.00
March 19 – 22, 2023	0636	Left blank	$0.00
March 19 – 22, 2023	0681	Left blank	$0.00
March 19 – 22, 2023	0710	Left blank	$0.00
March 19 – 22, 2023	0771	Left blank	$0.00
	Total	$21,936.71	$0.00

Requestor's Position

"Attached is a copy of a DWC-60 Form, EOB, UB04, an itemized statement, a copy of an appeal letter, a Medicare calculation worksheet from WEBPRICER.CMS.GOV, and medical records. The claim referenced below was billed as an inpatient visit, and the Medicare reimbursement is $21,936.71. The work comp reimbursement should be $21,936.71 (15,340.36 x 143%), however, we have yet to receive any payment from Liberty Mutual. We requested a review of the payment, and the reconsideration was denied.

Amount in Dispute: $21,936.71

Respondent's Position

"The carrier denied the bill with message 589 on 5/1/23. Message 589: *THE DOCUMENTATION RECEIVED DOS NOT SUPPORT THE LEVEL OF SERVICE BILLED. PLEASE ADJUST THE LEVEL OF SERVICE BILLED OR PROVIDE ADDITIONAL DOCUMENTATION TO SUPPORT THE SERVICE BILLED.* DRG of 511 is Shoulder, Elbow or forearm procedures, except major joint procedures with CC. With Clinical Coding Expert (CCE) software usage by the carrier, the diagnosis that is triggering the assignment of CC DRG is (redacted). The carrier does not argue that the injured worker has (redacted), 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. …For a patient with a chronic disease a significant acute manifestation of the chronic disease is required to be present and coded for the patient to be assigned a CC."

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 coding, billing, reporting and reimbursement of 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.
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.

Issues

1. Did the requestor support the submitted DRG was appropriately documented and supported by the clinical documentation?

Findings

1. The requestor is seeking reimbursement for inpatient hospital services rendered in March of 2023. The submitted DRG was 511 – Shoulder, elbows, or forearm procedures, except major joint procedures with CC. The insurance carrier denied the disputed services as documentation does not support the level of service billed.

   The Medicare Claims Processing Manual, Chapter 3, Section 20.2.2 – DRG Grouper Program states in pertinent part, "Each MS-DRG represents the average resources required to care for a case in that particular MS-DRG relative to the national average of resources."

   Comorbidities and Complications (CCs) are specific patient conditions that are secondary to the patient's primary diagnosis and require treatment during the stay.

   Review of the submitted medical record does not indicate how the indicated chronic condition required treatment during the stay.

   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

	Peggy Miller	October 13, 2023
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.