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 Medical Resources LLP

Respondent Name
LM Insurance Corp

MFDR Tracking Number
M4-24-0852-01

Carrier's Austin Representative
Box Number 60

DWC Date Received
December 12, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 5, 2023	111	$13,720.00	$0.00
April 5, 2023	250	$503.42	$0.00
April 5, 2023	272	$815.00	$0.00
April 5, 2023	278	$952.00	$0.00
April 5, 2023	300	$301.25	$0.00
April 5, 2023	301	$3,192.75	$0.00
April 5, 2023	305	$1,036.25	$0.00
April 5, 2023	309	$326.75	$0.00
April 5, 2023	320	$3,101.75	$0.00
April 5, 2023	360	$17,284.00	$0.00
April 5, 2023	370	$6,053.00	$0.00
April 5, 2023	420	$2,088.25	$0.00
April 5, 2023	424	$190.75	$0.00
April 5, 2023	430	$1,259.25	$0.00
April 5, 2023	434	$290.75	$0.00
April 5, 2023	450	$1,302.00	$0.00
April 5, 2023	636	$1,796.23	$0.00
April 5, 2023	681	$5,200.00	$0.00
April 5, 2023	710	$1,684.50	$0.00
April 5, 2023	730	$316.25	$0.00
April 5, 2023	921	$1,868.25	$0.00

Total	$63,282.40	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of their reconsideration that states, "The documentation in the medical record from 4/6/2023 from Dr. Dombroski supports that this interventional/surgical procedure was completed."

Amount in Dispute: $63,282.40

Respondent's Position

"This letter acknowledges receipt of your Network (HCN) complaint on December 19, 2023. Complaints must be made no later than 90 days after the date the issue arises that is the basis of the complaint."

Supplemental Response December 19, 2023

"The carrier argues that this diagnosis with this CC should not be paid when no supporting documentation has been received to show there was an increase level of care or increased consumption of services. There is no treatment for (redacted) documented in the medical records, so this cannot be used to pay a higher level DRG.

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 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.404 sets out the billing guidelines for inpatient medical services.

Denial Reasons

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

- 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.

Issues

1. Is the insurance carrier's denial supported?

Findings

1. The requestor is seeking reimbursement of an inpatient hospital stay from April 5, 2023. The insurance denied the claim as invalid DRG.

   DWC Rule 28 TAC §134.404(d) states in pertinent part, "For coding, billing, reporting, and reimbursement of health care… …Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided…"

   Review of the submitted medical bill finds the submitted DRG was 516 – "Other musculoskeletal system and connective tissue O.R. procedures with CC."

   Review of the submitted medical records did not support the surgical procedure rendered required treatment of any other condition(s). The "CC" or comorbidity was not supported. 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 additional 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	January 24, 2024 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.