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
MHHS Hermann Hospital

Respondent Name
First Liberty Insurance Corp

MFDR Tracking Number
M4-24-1706-01

Carrier's Austin Representative
Box Number 60

DWC Date Received
April 9, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 12 – 15, 2023	Inpatient Stay	$169,197.75	$26,247.22

Requestor's Position

"This is a bill for services provided by Memorial Hermann Hospital for a workers comp injury for the above named patient. The carrier has denied the medical bill stating the provider's Medicare number is invalid and the DRG is not valid for the inpatient stay. Our client's coding department reviewed this and believes this is correct."

Amount in Dispute: $169,197.75

Respondent's Position

"No payment is due until the correct DRG is billed to reflect the care that was given based on the medical records received. (redacted) as a complication during this admission to increase the cost to the facility based on the medical records received is not supported."

Response submitted by: Liberty Mutual Insurance

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 inpatient hospital facility fee guidelines. 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.
- 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.
- X598 – Claim has been re-evaluated based on additional documentation submitted. No additional payment due.

Issues

1. Is the respondent's denial supported?

2. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement for inpatient hospital services rendered July 2023. The insurance carrier denied the charges based on documentation that does not support the level of service. The insurance carrier's response to MFDR, states, "… The Carrier reviewed medical records received from the provider to support the usage of diagnosis code D62 and found no supporting evidence to pay DRG 513."

   The following sections in 28 TAC §134.404 outline the billing and coding requirements for inpatient hospital facilities.

   > (b)(3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing and reporting payment policies set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."
   >
   > (d) "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 with any additions or exceptions specified in this section…"

The applicable CMS coding and billing policy is found at www.cms.gov, MS-DRG classifications and software and states the following, "*Currently, cases are classified into Medicare Severity Diagnosis Related Groups (MS-DRGs) for payment under the IPPS based on the following information reported by the hospital: the principal diagnosis, up to 24 additional diagnoses, and up to 25 procedures performed during the stay*."

Review of the submitted medical records found the following.

- Discharge Summary – "All Diagnoses This Visit" (redacted)
- Emergency Department provider documentation "Musculoskeletal: …"(redacted)."
- Medical Decision Making – "Differential Diagnosis: (redacted)."
- Complexity of Problems Addressed "(redacted) to control bleeding with blood pressure cuff applied as tourniquet for hemostatic control.
- Assessment/Plan – 4. (redacted) Hb 13.5
- Operative Report – Preoperative Diagnosis – 4. (redacted)
- Operative Report – Procedure performed – 1. (redacted) artery repair under microscope magnification, CPT code 35207 and 69990 for use of the microscope.

Based on this review, the medical record does indicate that a diagnosis of (redacted) was documented. The insurance carrier's denial is not supported. The services in dispute will be reviewed per applicable fee guideline.

2. The payment of inpatient hospital services is subject to DWC Rule 28 TAC §134.404(f), that requires 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 PC Pricer* as a tool to efficiently identify and apply IPPS formulas and factors. This software is freely available from www.cms.gov.

   Separate reimbursement for implants was not requested. DWC Rule 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 513. The service location is Houston, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $18,354.70. This amount multiplied by 143% results in a MAR of $26,247.22.

3. The total recommended payment for the services in dispute is $26,247.22. This amount is recommended.

   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 reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that First Liberty Insurance Corp must remit to MHHS Hermann Hospital $26,247.22 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____	_____	August 15 , 2025
Signature	Medical Fee Dispute Resolution Officer	Date
_____	_____	August 15, 2025
Signature	Director Medical Fee Dispute Resolution	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.