



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Baylor Surgical Hospital at Trophy Club

Respondent Name

LM Insurance Corp

MFDR Tracking Number

M4-24-2559-01

Carrier's Austin Representative

Box Number 60

DWC Date Received

July 22, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 3, 2024	DRG 472	\$28,447.22	\$0.00
Total		\$28,447.22	\$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a document titled "Reconsideration" dated July 3, 2024 that states, "Per EOB received bill denied due to invalid DRG code. Please note that documentation support services being billed and DRG 472 is a valid coder per TX work comp guidelines."

Amount in Dispute: \$28,447.22

Respondent's Position

"The bill was processed correctly as the billed DRG 472 cervical spinal fusion with complications or comorbidities was not supported in the medical documentation. The complication/ comorbidity driving the DRG are acute (redacted). In the medical records, there is no report that the injured worker's hemoglobin fell to a level that required intervention or additional treatment. In addition, no lung or breathing issues were documented following the surgery. The DRG that was supported was one without complications. The provide did not bill appropriately for the

documentation provided.”

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 billing and reimbursement guidelines for inpatient hospital services.

Denial Reasons

- 16 – Claim/service lacks information which is needed for adjudication.
- 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.
- X598 – Claim has been re-evaluated based on additional documentation submitted; no additional payment due.
- U301 – This item has been reviewed on a previously submitted bill, or is currently in process. Notification of decision has been previously provided or will be issued upon completion of our review.

Issues

1. What are the rules applicable to submission of medical bills?

Findings

1. The requestor is seeking reimbursement of inpatient hospital services rendered in January 2024. The insurance carrier denied the disputed services as lacking information and submitted information not valid.

DWC Rule 28 TAC §134.404 (b)(3) states, “Medicare payment policy” means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting

payment policies as set forth in Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

DWC Rule 28 TAC §134.404 (d) states "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..."

Review of the submitted medical bill found the reported DRG is 472 with a description of "Cervical spinal fusion with CC." The use of this DRG is appropriate when the medical records reflect a complication or comorbidity.

DWC reviewed the submitted documentation but was unable to find any record of a major complication or comorbidity that significantly impacted patient care, treatment and use of resource utilization.

The insurance carrier's denial for lack of information and invalid DRG 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 additional reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

August 12, 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.