



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

MIDLAND MEMORIAL HOSPITAL

Respondent Name

LIBERTY INSURANCE CORP

MFDR Tracking Number

M4-16-2432-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

APRIL 13, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the applicable Texas fee schedule the correct allowable would be per the DRG 580. The allowable for this DRG per Medicare is \$9,903.38, we have also attached the print out for your review from the Medicare pricer program. The correct allowable would be at 143% making the allowable at \$14,161.83. Based on their payment of \$0, there is an additional of \$14,161.83, still due at this time."

Amount in Dispute: \$14,161.83

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The original billed DRG was 580 (Other skin, subcutaneous tissue & breast procedure with complication). The coded complication of ICD 6826 (cellulitis and abscess of leg, except foot) was not supported by the Discharge Summary. Please see the attached Discharge Summary....Documentation from medical records does not support code assignment of billed DRG."

Response Submitted by: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 17, 2015 through April 29, 2015	Inpatient Hospital Services	\$14,161.83	\$14,161.83

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.404, effective March 1, 2008, sets out the reimbursement guidelines for inpatient hospital services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - X045-DRG code considered invalid based on one or more of the following. 1. Incorrect DRG version per state fee schedule guidelines. 2. Incorrect assignment of one or more ICD-9 diagnosis or ICD-9 procedure codes. 3. Documentation from medical records does not support code assignment or billed DRG. Please review and

submit corrected billing form with revised DRG and, or documentation supporting DRG assignment.

- 193-Original payment decision is being maintained. Upon review , it was determined that this claim was processed properly.
- W3-Additional payment made on appeal/reconsideration.
- X598-Claim has been re-evaluated based on additional documentation submitted, no additional payment due.

Issues

1. Does the documentation support billing ICD-9 code 682.6?
2. Does the documentation support billing DRG code 580?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.404(b)(3) defines "'Medicare payment policy' means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

According to the submitted explanation of benefits, the respondent denied reimbursement for the inpatient hospitalization based upon reason code "X045-DRG code considered invalid based on one or more of the following. 1. Incorrect DRG version per state fee schedule guidelines. 2. Incorrect assignment of one or more ICD-9 diagnosis or ICD-9 procedure codes. 3. Documentation from medical records does not support code assignment or billed DRG. Please review and submit corrected billing form with revised DRG and, or documentation supporting DRG assignment."

The respondent contends that reimbursement is not due because "The coded complication of ICD 6826 (cellulitis and abscess of leg, except foot) was not supported by the Discharge Summary."

The Division reviewed the Progress Notes and finds that the requestor documented claimant had "edema," "blistering," and "cellulitis" in lower extremity. The Division finds that the documentation supports listing ICD-9 code 682.6 as secondary diagnoses.

2. The respondent also contends that the requestor billed with the incorrect DRG. A review of the submitted billing finds that the requestor billed DRG 580.

DRG-580 is defined as "Other skin, subcutaneous tissue & breast procedure with CC."

As stated above, the requestor noted in the progress notes that the claimant had complications in the lower extremity. The requestor also noted on the April 19, 2015 report that the claimant had "Strandy infiltrate or atelectasis in the left lung base."

The Division finds that the requestor supported billing code DRG 580, as a result, reimbursement is recommended.

3. To determine the MAR the Division refers to 28 Texas Administrative Code §134.404(f)(1)(A) which states "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied. (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by: (A) 143 percent."

Per 28 Texas Administrative Code §134.404(f)(1)(A), the MAR for DRG 580 is \$14,161.83. The respondent paid \$0.00. As a result, reimbursement of \$14,161.83 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$14,161.83.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$14,161.83 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

05/18/2016
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.