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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS HEALTH FORT WORTH

Respondent Name
MARKEL INSURANCE COMPANY

MFDR Tracking Number
M4-19-0260-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
September 17, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per DRG 907, claim was reimbursed under expected."

Amount in Dispute: $20,928.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor billed a DRG code that included complications. There were no complications found in the medical records. Therefore, Requestor was reimbursed for the lesser procedure that did not include complications."

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
April 5, 2018	Inpatient Hospital Surgery	$20,928.36	$0.00

FINDINGS AND DECISION

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

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.404 sets out the hospital facility fee guideline for inpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 350 – BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
   - 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE
   - B06 – REDUCTION/DENIAL BASED ON RESULTS OF PEER REVIEW. REDUCTION/DENIAL BASED ON RESULTS OF PROFESSIONAL REVIEW (RN, MD, DC, CPC)
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - PAID PER APPROPRIATE DRG CODE 494 BASED ON SUBMITTED DOCUMENTATION & APPLICABLE CODING-RESULTS OF PROFESSIONAL REVIEW (RN, MD, DC, CPC, OTHER MEDICAL PROFESSIONAL).

Issues

1. What is the appropriate DRG code for the disputed services?
2. Is the requestor entitled to additional payment?

Findings

1. The requestor asserts payment for the disputed services should be calculated using DRG code 907. The respondent however argues that after review, the carrier found DRG 494 to be the appropriate code.

   Rule §134.404(d) requires that for coding, billing, reporting, and reimbursement of covered health care, system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in division rules.

   Review of the requestor's position statement finds no explanation or information to support DRG code 907, defined as "Other Operating Room procedures for injuries *with* major complications/comorbidities."

   During the bill review process, the carrier determined payment for the services using DRG code 494: "Lower extremity and humerus procedures *without* complications or comorbidities."

   According to Medicare payment policy, the principal procedure billed, 0QSG06Z – "Reposition Right Tibia with Intramedullary Internal Fixation Device, Open Approach," may be reimbursed under either DRG code; however, per Medicare policy, the medical documentation must support the final selection of the DRG. Accordingly, the medical record must support the presence of major complications and comorbidities to justify payment under the higher level DRG code.

   Review of the operative report finds that the surgeon documented "Complications: none apparent." No other information was found in the records to support the presence of major complications or comorbidities. Consequently, the requestor has failed to support reimbursement under DRG code 907. The division concludes the carrier's determination of code 494 is supported as the appropriate DRG assignment.

2. This dispute regards inpatient services with payment subject to the *Hospital Facility Fee Guideline—Inpatient*, Rule §134.404, requiring 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 published in the Federal Register, with modifications set out in the rule. Medicare IPPS formulas and factors are available from the Centers for Medicare and Medicaid Services at http://www.cms.gov.

   Separate reimbursement for implantables was not requested; accordingly, Rule §134.404(f)(1)(A) requires that for these services the Medicare facility specific amount, including any outlier payment, be multiplied by 143%.

   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 also freely available from www.cms.gov.

   Review of the submitted medical bill and supporting documentation finds the DRG code to be 494. The service location is Fort Worth. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $11,577.97. This amount multiplied by 143% results in a MAR of $16,556.50. The insurance carrier has paid $16556.50, leaving an amount due to the requestor of $0.00. No additional payment is recommended.

Conclusion

The division emphasizes that the findings in this decision are based on the evidence presented by the requestor and respondent available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

______________________	Grayson Richardson	November 16, 2018
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 in accordance with Rule §133.307.

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 form's instructions. The division must receive the request within twenty days of your receipt of this decision. The request may be faxed, mailed or personally delivered either to the division, using the contact information listed on the form, or to the field office handling the claim.

The party seeking review must deliver a copy of the request to all parties involved in the dispute at the same time the request is filed. Include a copy of this *Medical Fee Dispute Resolution Findings and Decision* together with any other information required by 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.