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
South Texas Health System

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-09-9319-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 10, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The insurance carrier should pay this claim appropriately at $13,703.03."

Amount in Dispute: $13,703.03

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor initially submitted its bill with DRG 225. The carrier denied the service stating, 1) 'itemized statement required and 2) service not justified,' with additional information printed on the EOB which clearly stated, 'DRG 225 billed is for cardiac defibrillator with cardiac catheter. This does not appear to be consistent with the work-related injury of crushing injury to foot.'… The requestor re-filled its bill on 8/20/08 with the same DRG of 225… Texas Mutual declined to issue payment."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 18-21, 2008	Inpatient Hospital Stay	$13,703.03	$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 §133.2 provides definitions relating to medical billing and processing.
3. 28 Texas Administrative Code §133.20 sets out the procedures for medical bill submission by a health care provider.
4. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of a medical bill.
5. 28 Texas Administrative Code §134.404 sets out the guidelines for billing and reimbursing inpatient facility

services.

6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-16 – Claim/service lacks information which is needed for adjudication.
   - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
   - 895 – In order to analyze the attached billing we will need a copy of the itemized billing.
   - Notes: "225, 892 – DRG 225 BEING BILLED IS FOR CARDIAC DEFIBRILLATOR WITH CARDIAC CATHETER. THIS DOES NOT APPEAR TO BE CONSISTENT WITH THE WORK-RELATED INJURY OF CRUSHING INJURY TO FOOT."
   - CAC-W1 – Workers compensation state fee schedule adjustment.
   - CACC-W4 – No additional reimbursement allowed after review of appeal/reconsideration.
   - 891 – The insurance company is reducing or denying payment after reconsideration.
   - 892 – Denied in accordance with DWC rules and/or medical fee guideline.
7. Dispute History:
   - The dispute was originally decided on May 9, 2009 under MFDR Tracking Number M4-09-6818-01.
   - The decision was withdrawn on June 10, 2009.
   - The dispute was re-docketed under MFDR Tracking Number M4-09-9319-01 on June 10, 2009.
   - M4-09-9319-01 is herein reviewed.

Issues

Is the requestor entitled to additional reimbursement?

Findings

A complete medical bill for an inpatient hospital stay using DRG billing code 225 was denied by the insurance carrier with claims adjustment code "225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information." The same billing code was resubmitted as a request for reconsideration and again denied by the insurance carrier using the same claims adjustment code.

28 Texas Administrative Code §134.404 (d) effective March 1, 2008, 33 TexReg 400, states, in relevant part, "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, including the following paragraphs ... (3) Whenever a component of the Medicare program is revised and effective, use of the revised component shall be required for compliance with Division rules, decisions, and orders for services rendered on and after the effective date, or after the effective date or the adoption date of the revised Medicare component, whichever is later."

In addition, 28 Texas Administrative Code §133.20 (c), effective May 2, 2006, 31 TexReg 3544, states, "A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills."

On the dates of service in dispute, billing code 225 represented services for "cardiac defibrillator implant with cardiac catheterization, without acute myocardial infarction/heart failure/shock without MCC." Both the requestor and the insurance carrier agree that DRG billing code 225 was not the correct billing code for the services performed. Therefore, the insurance carrier's denial is supported and no further reimbursement is recommended.

The Division notes that both parties discuss timely filing of a bill submitted on October 13, 2008. However, no denial of this bill was found in the submitted documentation. The Division further notes that a health care provider is required to submit a complete medical bill in accordance with 28 Texas Administrative Code §133.20 (b), effective May 2, 2006, 31 TexReg 3544, which states, "A health care provider shall not submit a medical bill later than the 95th day after the date the services are provided."

Conclusion

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 upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	July 24, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MFDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of this *Medical Fee Dispute Resolution Findings and Decision***, together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

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