



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

HOUSTON ORTHOPEDIC
SURGICAL HOSPITAL, LLC

Respondent Name

HOUSTON GENERAL INSURANCE CO

MFDR Tracking Number

M4-14-0958-01

Carrier's Austin Representative Box

Box Number 11

MFDR Date Received

November 25, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are submitting this appeal due to a short payment made on this bill. We are requested "seeking separate reimbursement" on implants located in box 80 located on the UB form. Corvel, EOR states \$7,024.04 was paid on the rev code 278 for the implants. Per Texas Fee Guidelines for Workers Compensation if seeking separate reimbursement on implants we are to be paid 100% of our cost. Total cost for implants used in this case were \$38,635.49 minus your short payment of \$7,024.04 makes you short \$31,611.85. Enclosed are the invoices for the implants and IMPLANT RECORD. Previously submitted medical documentation is attached."

Amount in Dispute: \$31,611.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on December 03, 2013. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 23, 2013 through May 06, 2013	Inpatient Hospital Surgical Services	\$31,611.85	\$31,611.85

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 amended to be effective May 31, 2012, 37 Texas Register 3833, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.

2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 193 – Original payment decision maintained
 - B13 – Payment for services may have been previously paid L2S I/O Poly Screw
 - B13 – Payment for service may have been previously paid DBX putty 10cc
 - B13 – Payment for service may have been previously paid MTF crshed canc 30cc
 - 105 – Additional information needed to review charges
 - 16 – Not all info needed for adjudication was supplied
 - Imp – Implant/ DME allowance
 - W1 – Workers’ Compensation State Fee Schedule

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Which reimbursement calculation applies to the services in dispute?
3. What is the maximum allowable reimbursement for the services in dispute?
4. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code §134.404(e) states that: “Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
 - (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
 - (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables.”

No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under §134.404(f).

2. §134.404(f) states that “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; unless
 - (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent.”

Review of the documentation finds that that the facility requested separate reimbursement for implantables; for that reason, the requirements of subsection (g) apply.

3. §134.404(g) states, in pertinent part, that “(g) Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission.
 - (1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

Review of the documentation found supports that the following items were certified as required by (g):

Itemized Statement Rev Code or Charge Code	Itemized Statement Description	Cost Invoice Description	# Units & Cost Per Unit	Cost Invoice Amount	<i>Per item</i> Add-on (cost +10% or \$1,000 whichever is less).
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278	SURGIFLO MATRIX	SURGIFLO/LYOTH ROMBIN	2 at \$1,145.82 ea	\$2,291.64	\$2,520.80
278	INT DURAGEN MTX 3X3	DP1033/DURAGEN PLUS DURAL REGNERATION MATRIX 3X3	1 at \$911.00 ea	\$911.00	\$1,002.10
278	DBX PUTTY 10CC	DBX PUTTY 10CC	1 at \$287.75 ea	\$287.75	\$316.53
278	MTF CRSHD CANC 30CC	CRUSHED CANCELLOUS 30CC	2 at \$597.55 ea	\$1,195.10	\$1,314.61
278	L2S I/O POLY SCREW	NO INVOICE FOUND	\$0.00	\$0.00	\$0.00
278	CRLK CAP PRICE ADD	NO INVOICE FOUND	\$0.00	\$0.00	\$0.00
278	CRLK CAP PRICE ADD	NO INVOICE FOUND	\$0.00	\$0.00	\$0.00
278	CRLK CAP PRICE ADD	NO INVOICE FOUND	\$0.00	\$0.00	\$0.00
278	CS DURASEAL SEALANT	NO INVOICE FOUND	\$0.00	\$0.00	\$0.00
				\$4,685.49	\$5,154.04
				Total Supported Cost	Sum of Per-Item Add-on

The division finds that the facility supported separate reimbursement for these implantables, and that the cost invoices were certified as required. Therefore, the MAR is calculated according to §134.404(f)(1)(B).

4. §134.404(f)(1)(B) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 108%, **plus** reimbursement for items appropriately certified under §134.404(g). The Medicare IPPS payment rates are found at <http://www.cms.gov>, and the sum of the per-item add-on for which separate reimbursement was requested are taken from the table above.
 - Documentation found supports that the DRG assigned to the services in dispute is 457, and that the services were provided at HOUSTON ORTHOPEDIC SURGICAL HOSPITAL, LLC. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of \$43,994.25. This amount multiplied by 108% results in an allowable of \$47,513.79.
 - The total cost for implantables from the table above is \$4,685.49. The sum of the per-billed-item add-ons does not exceed the \$2000 allowed by rule; for that reason, total allowable amount for implantables is \$4,685.49 plus \$468.55, which equals 5,154.04.

Therefore, the total allowable reimbursement for the services in dispute is \$47,513.79 plus \$5,154.04, which equals \$52,667.83. The respondent issued payment in the amount of \$7,024.04. Based upon the documentation submitted and the *Table of Disputed Services*, additional reimbursement in the amount of \$31,611.85 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

