



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

USMD HOSPITAL AT FORT WORTH

Respondent Name

TASB RISK MANAGEMENT FUND

MFDR Tracking Number

M4-14-2921

Carrier's Austin Representative

Box Number 47

MFDR Date Received

May 19, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a claim for inpatient services and we did request separate reimbursement, the claim should have allowed at 108% of Medicare's DRG rate and 110% of the billed charges for the implant invoices. . . . We ask that you review the Medical Fee Dispute for additional payment based on Rule 134.404(f)"

Amount in Dispute: \$1,499.52

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Fund reimbursed according to Medicare IPPS based on DRG at \$22,203.25 multiplied by 108% = 23,979.51. . . . The original reimbursement for implants was overpaid. The total reimbursement for implants should have been \$19,866.88."

Response Submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 11, 2013 to July 13, 2013	Implantables	\$1,499.52	\$0.00

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

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 fee guidelines for inpatient acute care hospital services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W1 – Workers Compensation State Fee Schedule Adjustment
 - W3 – Additional payment made on appeal/reconsideration.
 - 12/12/13 – paid at 108% as this is percentage for inpatient charge with implants paid separately.
 - 12/12/13 – Rule 134.804 (A) Services reviewed for reconsideration.
 - Additional payment made or service adjustment amount may be zero.

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - 12/12/13 Applies to all lines.
 - 12/12/13 – Maintain original denial on this line item as this is part of inpatient charge.
 - Negotiated

Issues

1. May the respondent raise new denial reasons or defenses?
2. Are the disputed services subject to a contractual or negotiated fee agreement?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the implantables in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The respondent's position statement asserts several denial reasons and defenses that were not found listed in the explanations of benefits submitted by the parties. 28 Texas Administrative Code §133.307(d)(2)(F), effective May 31, 2012, 37 *Texas Register* 3833, states that "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." No documentation was found to support that the respondent presented these denial reasons to the requestor prior to the date that the request for medical dispute resolution was filed with the Division, therefore these newly raised denial reasons or defenses shall not be considered in this review.
2. The insurance carrier denied or reduced payment for disputed services with the additional payment comment "Negotiated." Review of the submitted information finds no documentation to support a negotiated fee agreement between the parties to this dispute, nor any documentation to support a contractual fee arrangement applicable to the disputed services. The insurance carrier's payment reduction explanation is not supported. Reimbursement will therefore be considered per applicable Division rules and fee guidelines.
3. This dispute relates to implantables, billed under revenue code 278, with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.404(g) which provides that "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." Documentation was found to support that the facility requested separate reimbursement for implantables.
4. Review of the submitted documentation finds that the disputed implantables include:
 - "SCREW SET 4.75 TI 5440030" as identified in the itemized statement and labeled on the invoice as "SET SCREW 5440030 4.75 TI NS BRK OFF" with a cost per unit of \$170.40 at 2 units, for a total cost of \$340.80;
 - "CONNECTOR ROD TO ROD 778145545" as identified in the itemized statement and labeled on the invoice as "CONNECTOR 778145545 TI SDLD SD5.5 CL4.5" with a cost per unit of \$1,248.00 at 2 units, for a total cost of \$2,496.00;
 - "SCREW 5.5X30MM 54840005530" as identified in the itemized statement and labeled on the invoice as "SCREW 54840005530 MAS 5.5X30 CC" with a cost per unit of \$1,345.60;
 - "ROD SOLERA 50MM 1475501050" as identified in the itemized statement and labeled on the invoice as "ROD 1475501050 4.75 CCM NS CURV 50MM" with a cost per unit of \$504.00 at 2 units, for a total cost of \$1,008.00;
 - "INTERFUSE DEVICE 9076-08-20-5" as identified in the itemized statement and labeled on the invoice as "InterFuse S 9076-08-20-5" with a cost per unit of \$6,800.00;
 - "TISSUE VCBM 10CC STM010" as identified in the itemized statement and labeled on the invoice as "CELLENTRA VCBM - 10CC" with a cost per unit of \$3,816.00;
 - "SET SCREW STD 1/4-32 779170005" as identified in the itemized statement and labeled on the invoice as "SET SCREW 779170005 TI SDTD 1/4-32" with a cost per unit of \$160.00 at 4 units, for a total cost of \$640.00;

- "SCREW HA 5.5X35MM 55740105535" as identified in the itemized statement and labeled; however, no invoice or documentation of the manufacturer's invoice amount, or the net amount (exclusive of rebates and discounts), was submitted for this item. Additional reimbursement cannot be recommended.
- Additionally, the Division notes that the provider charged for and then subsequently removed the charge for "SCREW 5.5X35MM 54740105535" as identified in the itemized statement. The charge is not included in the billed amount for implantables on the medical bill. Review of the submitted documentation finds an invoice referencing this item, identified on the invoice as "SCREW 54740105535 4.75 HA MAS 5.5X35 CC." The Division notes that the item number on the invoice matches the item number of the implantable charge that was removed from the itemized statement. As this item was not provided to the injured employee, it is not eligible for reimbursement.

The total net invoice amount (exclusive of rebates and discounts) is \$16,446.40. The total add-on amount of 10% or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission is \$1,644.64. The total recommended reimbursement amount for the implantable items is \$18,091.04.

5. The total allowable reimbursement for the implantables in dispute is \$18,091.04. Documentation was found to support insurance carrier payment of \$24,929.08 toward these disputed items, leaving an amount due to the requestor of \$0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has failed to establish 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 services in dispute.

Authorized Signature

	Grayson Richardson	August 7, 2014
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 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.