



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

PINE CREEK MEDICAL CENTER

Respondent Name

LIBERTY INSURANCE CORP

MFDR Tracking Number

M4-15-2717-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

April 24, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Pine Creek Medical Center was paid a total of \$18,219.73 however our facility was under paid for the implants.

A request for reconsideration was submitted on 12/4/14 to Liberty Mutual requesting that they re-review all supporting documentation and remit additional payment for implants that were provided to the above claimant.

Pine Creek Medical Center received a denial EOB dated 12/18/14 which indicated no additional payment was recommended."

Amount in Dispute: \$708.82

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have received the medical dispute filed by Pine Creek Medical Center for services rendered to [injured employee] for the 06/30/2014 date of service. The bill and documentation attached to the medical dispute have been re-reviewed and our position remains unchanged. Our rationale is as follows:

The provider is requesting separate reimbursement for "Tisseel". This product is a Fibrin Sealant is indicated for mesh fixation in hernia repair, as an alternative or adjunct to sutures and staples. TISSEEL contains fibrinogen and thrombin and is also indicated as supportive treatment where standard surgical techniques are insufficient, for improvement of haemostasis, as a tissue glue to promote adhesion, sealing or as suture support, in gastrointestinal anastomoses, in neurosurgery where contact with cerebrospinal fluid or dura mater may occur. It is not a implantable device but rather glue that contains fibrinogen and thrombin."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: June 30, 2014, Inpatient Hospital Services, \$708.82, \$708.82

## **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 acute care hospital fee guideline for inpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - Z710 – The charge for this procedure exceeds the fee schedule allowance
  - P300 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
  - 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
  - X212 – This procedure is included in another procedure performed on this date

### **Issues**

1. What is the applicable rule for determining reimbursement of the disputed services?
2. What is the recommended payment for the services in dispute?
3. What is the additional recommended payment for the implantable items in dispute?
4. Is the requestor entitled to additional reimbursement?

### **Findings**

1. This dispute relates to facility medical services provided in an inpatient acute care hospital. No documentation was found to support that the services are subject to a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011. Reimbursement is therefore subject to the provisions of 28 Texas Administrative Code §134.404(f), which states:

The reimbursement calculation used for establishing the MAR [maximum allowable reimbursement] 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 submitted documentation finds that separate reimbursement for implantables was requested; for that reason, the MAR is calculated according to §134.404(f)(1)(B).

2. Per §134.404(f)(1)(B), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment by 108%. Information regarding the calculation of Medicare IPPS payment rates may be found at <http://www.cms.gov>. Review of the submitted documentation finds that the DRG code assigned to the services in dispute is 470. The services were provided at PINE CREEK MEDICAL CENTER. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is \$11,958.95. This amount multiplied by 108% results in a MAR of \$12,915.67.
3. Additionally, the provider requested separate reimbursement of implantables. Per §134.404(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.

Review of the submitted documentation finds that the separate implantables include:

- Palacos R 1 X 40 Single
- Bone Pin 4 X 80mm Sterile
- Bone Pin 4 X 140mm Sterile
- MCK Femoral Lm RL SZ 4
- MCK Tibial Baseplate LM/RL SZ 3
- MCK Tibial Onlay Insert SZ 3-8mm
- Per §134.404(b)(2), "Implantable" means an object or device that is surgically:
  - (A) implanted,
  - (B) embedded,
  - (C) inserted,
  - (D) or otherwise applied, and
  - (E) related equipment necessary to operate, program and recharge the implantable.

The health care provider billed for a "IMP TISSELL 10ml (FREEZER)" as identified in the itemized statement and labeled on the invoice as "TISSEEL CH SD 10 ML FZN SPD." Review of the submitted documentation finds insufficient documentation to support that this item was implanted or meets the definition of an implantable under §134.404(b)(2). Separate reimbursement is not recommended.

The total net invoice amount (exclusive of rebates and discounts) is \$4,937.25. 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 \$493.73. The total recommended reimbursement amount for the implantable items is \$5,430.98.

4. The total recommended payment for the services in dispute is \$18,346.64. This amount less the amount previously paid by the insurance carrier of \$5,064.46 leaves an amount due to the requestor of \$708.82. The requestor is seeking \$708.82. This amount 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 \$708.82.

### ***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 \$708.82 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

\_\_\_\_\_  
5/29/15  
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 MFDR 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.**