



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

HOUSTON ORTHROPAEDIC SURGICAL

Respondent Name

EMPLOYERS INSURANCE CO OF WAUSAU

MFDR Tracking Number

M4-15-3373-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

June 12, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please process and pay my Request for Reconsideration. Liberty Mutual payment was only for the surgery in the amount of \$22,212.85. You failed to pay separate reimbursement in implants. That request was in box 80 located on the UB form. Liberty Mutual, EOR states zero was paid on the implants Per Medicare Fee Schedule payment should be \$16,175.39 @ 90% \$14,557.85 Implants \$21,099.84 with 10% markup \$2,000.00. Expected payment should have been \$37,657.69 - \$22,212.85 your payment= \$15,444.84 short. Enclosed are the invoices for the implants, they were submitted originally with the claim. Payment is now due in full."

Amount in Dispute: \$15,444.48

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We base our payments on the Texas Fee Guidelines and the Texas Department of Insurance/Division of Workers' Compensation Commission's Acts and Rules.

We have received the medical dispute filed by Houston Orthopaedic Surgical for services rendered to [injured employee] for the 11/17/2014 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 bill was reimbursed at 143% of the providers' Medicare IPPS rate to total \$22,351. The provider did not request separate implant reimbursement upon submission as outlined in the Texas Workers Compensation Fee Schedule."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 17, 2014 through November 21, 2014	Inpatient Hospital Services	\$15,444.48	\$15,444.48

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
 - U634 – Procedure code not separately payable under Medicare and or fee schedule guidelines
 - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment
 - W3 – Additional payment made on appeal/reconsideration
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

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 468. The services were provided at HOUSTON ORTHROPAEDIC SURGICAL. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is \$15,715.92. This amount multiplied by 108% results in a MAR of \$16,973.19.
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:

- DBOX PUTTY 10 CC
- ST SIMPLEX CEM TOBRA
- SN LEGION REV TIB BS
- SN LGN SCR DIS FEM W
- SN GEN CNSTR ART INS
- SN LEGION PRSFIT STD
- SN LEGION PRSFIT STD
- SN LGN OX CONSTRND FM
- SN LGN HM TIBIAL WDG

The total net invoice amount (exclusive of rebates and discounts) is \$16,973.19. 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 \$23,099.84. The total recommended reimbursement amount for the implantable items is \$23,099.84.

4. The total recommended payment for the services in dispute is \$40,073.03. This amount less the amount previously paid by the insurance carrier of \$22,351.53 leaves an amount due to the requestor of \$15,444.48. The recommended allowance in the amount of \$15,444.48 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 \$15,444.48.

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 \$15,444.48 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

7/17/15
Date

Signature

Medical Fee Dispute Resolution Manager

7/17/15
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.