



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

BAYLOR SURGICAL HOSPITAL

Respondent Name

CASTLEPOINT NATIONAL INSURANCE

MFDR Tracking Number

M4-15-3706-01

Carrier's Austin Representative

Box Number 17

MFDR Date Received

July 13, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim involved implants. We are requesting separate payment of the cost of implants plus 10% as indicated in these guidelines.

Total cost of implants for this case was \$21,925.00 Cost \$21,925.00 x 10% = \$22,925.00 Expected implant reimbursement: \$19,644.42

Reimbursement of \$38,515.63 was received leaving an amount due of \$1,717.65."

Amount in Dispute: \$1,717.65

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent paid a total of \$39,515.63 for the total inpatient procedure performed on 4/4/15. Payment was calculated using the Medicare Fee Guidelines and the documentation submitted. No additional monies are owed to Requestor."

Response Submitted by: Downs Stanford, P.C. 2001 Bryan Street Suite 4000 Dallas TX 75201

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: April 02, 2015 to April 04, 2015, Inpatient Hospital Services, \$1,717.65, \$1,108.14

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:
  - W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
  - 350 – Bill has been identified as a request for reconsideration or appeal
  - P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment
  - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline

### **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 BAYLOR SURGICAL HOSPITAL. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is \$15,461.82. This amount multiplied by 108% results in a MAR of \$16,698.77.
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:

"REVISION KNEE FEMUR RIGHT" as identified in the itemized statement and labeled on the invoice as "REVISION CEMENTED FUMR-RIGHT SIZE 4" with a cost per unit of \$9,175.00; "COMPONENT STEM 20MM X 80" as identified in the itemized statement and labeled on the invoice as "FEMORAL & TIBIAL STEM 20MM X 80 MM" with a cost per unit of \$1,860.00 at 2 units, for a total cost of \$3,720.00; "BUSHING VALGUS ASSEMBLY" as identified in the itemized statement with a cost per unit of \$635.00; "TRAY TIBIAL REVISION KNEE" as identified in the itemized statement with a cost per unit of \$4,875.00; "BUSHING ASSEMBLY

TIBIAL" as identified in the itemized statement with a cost per unit of \$635.00; "INSERT TIBIAL REVISION F" as identified in the itemized statement with a cost per unit of \$2,885.00.

Per §134.404(f)(2), when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.404(g). The facility's total billed charges for the separately reimbursed implantable items are \$21,925.00. Accordingly, the facility's total billed charges shall be reduced by this amount for the purpose of calculating any outlier payments.

The total net invoice amount (exclusive of rebates and discounts) is \$21,925.00. 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 \$2,000.00. The total recommended reimbursement amount for the implantable items is \$23,925.00.

4. The total allowable reimbursement for the services in dispute is \$40,623.77. This amount less the amount previously paid by the insurance carrier of \$39,515.63 leaves an amount due to the requestor of \$1,108.14. 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 \$1,108.14.

### ***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 \$1,108.14 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

\_\_\_\_\_  
8/14/15  
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.**