



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

DOCTORS HOSPITAL AT RENAISSANCE

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-16-0916-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

December 09, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.402 Facility Fee Guideline Inpatient states that the reimbursement is 143% of the Medicare Facility specific reimbursement amount and any applicable outlier payment.

After reviewing the account we have conclude that reimbursement received was inaccurate. Based on DRG 300, allowed amount is \$14,005.43; multiplied at 108% would be \$15,125.86 + \$10,559.82 (implants). The reimbursement amount should be \$25,685.71. Payment received was only \$20,700.25, thus according to these calculations; there is a pending payment in the amount of \$4,985.46.

We rendered services on good faith based on information that was exchanged and therefore are also requesting that our claim be processed for additional payment."

Amount in Dispute: \$1,555.79

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual Insurance Company received a TWCC-60 form the above-mentioned requester. Pursuant to Commission Rule 133.307(d) Texas Mutual files the attached, completed response, and related items.

The following is the carrier's statement with respect to this dispute of 3/9/2015 to 3/11/2015. The requester argues an additional \$1,555.79 is due but does not explain how or why. Texas Mutual believes its payment of \$23,422.77 was correct and no additional payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 09, 2015 to March 11, 2015	Inpatient Hospital Services	\$1,555.79	\$1,555.79

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:
 - CAC-P12 – Workers Compensation Jurisdictional fee schedule adjustment
 - CAC-W2 – In accordance with TDI DWC Rule 134.804. This bill has been identified as a request for reconsideration or appeal
 - CAC-193 – Original payment decision is being maintained. Upon review it was determined that his clam was processed properly
 - CAC-97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
 - 217 – The value of this procedure is included in the value of another procedure performed on this date
 - 350 – In accordance with TDI-DWC Rule 134.804 This bill has been identified as a request for reconsideration or appeal
 - 420 – Supplemental payment
 - 468 – Reimbursement is based on the Medical Hospital Inpatient Prospective Payment System Methodology
 - 891 – No additional payment after reconsideration
 - CAC-W3 – In accordance with TDI DWC Rule 134.804 This bill has been identified as a request for reconsideration or appeal
 - CAC-18 – Exact duplicate claim/service
 - 878 – Appeal (request for reconsideration) previously processed refer to Rule 133.250(H)

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 030. The services were provided at DOCTORS HOSPITAL AT RENAISSANCE. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is \$13,350.66. This amount multiplied by 108% results in a MAR of \$14,418.71.
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:

"OR Floseal Hemostatic Matrix 5ML" as identified in the itemized statement and labeled on the invoice as "Floesal VHSD 5ML NDLFREE 6pk" with a cost per unit of \$959.23; "Ortho Bone cursh Cancellous 4-10MM" as identified in the itemized statement and labeled on the invoice as "60cc Cancellous Crushed" with a cost per unit of \$730.00 at 2 units, for a total cost of \$1,460.00; "Orth Spine Spacer Danek Capstone PE" as identified in the itemized statement and labeled on the invoice as "Spacer Capstone Peek 09X23" with a cost per unit of \$1,800.00; "Orth Spine Spcaer Danek Capstone PE" as identified in the itemized statement and labeled on the invoice as "Capstone Peek 08X22" with a cost per unit of \$1,800.00; "Ortho Spine ROD (MSD) C Horizon SOL" as identified in the itemized statement and labeled on the invoice as "Rod 4.75 CCM NS Curv 60MM" with a cost per unit of \$150.00 at 2 units, for a total cost of \$300.00; "Orth Spine Multi-axial Cobalt 4.5/9.5MM" as identified in the itemized statement and labeled on the invoice as "Screw MAS 6.5X45CC" with a cost per unit of \$760.00 at 4 units, for a total cost of \$3,040.00; "Orth Spine Multi-axial Cobalt 4.5/9.5MM" as identified in the itemized statement and labeled on the invoice as "Screw Mas 6.5X50CC" with a cost per unit of \$760.00 at 2 units, for a total cost of \$1,520.00; "Ortho Spine Screw Set (MSD)" as identified in the itemized statement and labeled on the invoice as "Set Screw 4.75 TI NS Brk OFF" with a cost per unit of \$90.00 at 6 units, for a total cost of \$540.00.

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 \$125,141.09. 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 \$11,419.23. 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 \$1,141.92. The total recommended reimbursement amount for the implantable items is \$12,561.15.

4. The total allowable reimbursement for the services in dispute is \$26,979.87. The amount previously paid by the insurance carrier is \$23,422.77. The requestor is seeking additional reimbursement in the amount of \$1,555.79. 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 \$1,555.79.

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 \$1,555.79 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

12/22/15
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.