



# 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**

Liberty Insurance Corp

**MFDR Tracking Number**

M4-16-2191-01

**Carrier's Austin Representative**

Box Number 01

**MFDR Date Received**

March 29, 2016

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "According to TWCC guidelines, Rule §134.404 Facility Fee Guideline-Inpatient states that the reimbursement is 143% of the Medicare Facility specific reimbursement amount and any applicable outlier payment."

**Amount in Dispute:** \$6,149.58

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Also, the LOS does not impact the DRG allowance and 3 days were pre-authorized. However, the last 4 days were disallowed as pre-authorization was required, but not requested for this service per DWC Rule 134.600."

**Response Submitted by:** Liberty Mutual

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 25, 2015 through October 2, 2015	Inpatient Hospital Services	\$6,149.58	\$1,261.53

#### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.404 sets out the acute care hospital fee guideline for inpatient services.
- 28 Texas Administrative Code §134.600 sets out the requirements for prior authorization.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - X170 – Pre authorization was required but not requested for this service per DWC rule 134 600
  - Z710 – The charge for this procedure exceeds the fee schedule allowance

- P300 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
- X023 – Payment for charge is not recommended without an invoice or documentation of cost for reconsideration please submit appeal with EOP and documentation of cost and or attestation statement of cost as required by state fee schedule guidelines
- X212 – This procedure is included in another procedure performed on this date
- B13 – Previously paid payment for this claim/service may have been provided in a previous payment
- 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

### **Issues**

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule for determining reimbursement of the disputed services?
3. What is the recommended payment for the services in dispute?
4. What is the additional recommended payment for the implantable items in dispute?
5. Is the requestor entitled to additional reimbursement?

### **Findings**

1. The insurance carrier reduced or denied payment for the disputed services with claim adjustment reason code X170 – "Pre authorization was required but not requested for this service per DWC Rule 134 600." 28 Texas Administrative Code §134.600 (p)(1) requires that, "Non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay." Review of the submitted information finds insufficient evidence that authorization for the entire inpatient stays was authorized. The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended for dates of service September 28, 2015 through October 1, 2015. The carrier states, "The Redmed, Inc. (nonMFR) invoice submitted for one 30cc cancellous bone and one 5cc DBM putty has been disallowed requesting a MFR invoice." Review of the submitted documentation finds an invoice for the service in dispute. 28 Texas Administrative Code 134.403(g) states,

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.

- (1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

The Division finds the requestor has met requirements of Rule 134.403(g)(1) and therefore these services will be reviewed per applicable rules and fee guidelines.

2. This dispute regards the facility medical services of an inpatient acute care hospital with reimbursement subject to the provisions of Code 28 Texas Administrative Code §134.404(f), which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) 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 with the application of minimal modifications as set forth in the rule.

Per §134.404(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 143 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that

separate reimbursement for implantables was requested. Therefore, per §134.404(f)(1)(B), the facility specific reimbursement amount, including any outlier payment, shall be multiplied by 108 percent.

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 \$125,992.14. Accordingly, the facility's total billed charges shall be reduced by this amount when calculating outlier payments.

3. Per §134.404(f)(1)(B), the facility specific reimbursement amount, including any outlier payment, shall be multiplied by 108 percent. 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 460. 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 \$26,625.64. This amount multiplied by 108% results in a MAR of \$28,755.69.
4. Additionally, the provider requested separate reimbursement of implantables. Per §134.404(g), when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B), implantables are 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. The total net invoice amount (exclusive of rebates and discounts) is \$11,104.40. 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 \$11,104.40. The total recommended reimbursement amount for the implantable items is \$12,214.84.
5. The total recommended payment for the services in dispute is \$40,970.53. The insurance carrier has paid \$39,709.00. The amount due to the requestor is \$1,261.53. 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 \$1,261.53.

***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$1,261.53, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

**Authorized Signature**

		April 26, 2016
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 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.**