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
Wausau Underwriters Insurance

MFDR Tracking Number
M4-17-3096-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
June 20, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Pine Creek Medical Center was paid a total of $18,470.97 on 8/31/16 for an Inpatient procedure. A request for reconsideration was submitted on 4/12/17 to Liberty Mutual requesting that the claim be re-review [sic} as there was no payment for the implants. Liberty Mutual denied the appeal indicating no additional payment is due."

Amount in Dispute: $13,104.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The original bill was received o 8/17/2016 and submitted without Revenue code 278… The bill priced per submitted DRG 473 @143% CMS' IPPS rate, or $18.470.97."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 27 - 28, 2016	Inpatient Hospital Services	$13,104.00	$0.00

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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.10 sets out required billing forms/formats.
3. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P300 – The amount paid reflects a fee schedule reduction

- Z710 – The charge for this procedure exceeds the fee schedule allowance

Issues

1. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking separate reimbursement for implantables that were provided as part of the inpatient hospital services in dispute. The hospital in this case argues that it should have been paid separately for the implantables.

   28 Texas Administrative Code §134.403(f)(1), states in pertinent part

   > (f) The reimbursement calculation used for establishing the 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. 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.

   28 Texas Administrative Code §133.10 (f)(2)(QQ) furthermore **requires** that the hospital use a specific field on the UB-04 to make such a request for separate reimbursement:

   > (QQ) remarks (UB-04/field 80) is required when separate reimbursement for surgically implanted devices is requested.

   Review of the submitted medical bill created August 9, 2016 finds this original bill did not contain the required data in field 80. As the requestor failed to include the remarks in field 80 of the UB-04 required to trigger separate reimbursement for implantables the Division finds the carrier processed this bill per the guidelines of 28 Texas Administrative Code §134.403(f)(1)(A).

   Because the requestor failed to support that it requested separate reimbursement in accordance with the applicable rules, the Division finds that no additional reimbursement is due.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Peggy Miller	July 7, 2017
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, 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.