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
PINE CREEK MEDICAL CENTER

Respondent Name
LIBERTY INSURANCE CORPORATION

MFDR Tracking Number
M4-18-0272-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
October 2, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 8/17/17 I called Liberty Mutual Bill Review . . . who advised me that the DX Code . . . is causing the claim to deny. . . . advised me to submit a corrected 137 claim as an appeal/reconsideration and claim will be paid. . . . On 8/22/17 the corrected 137 claim was submitted as an appeal. . . "

Amount in Dispute: $33,814.05

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "payment should have been made on the billed DRG. This has now been corrected to pay DRG at the 108% rate per Texas Fee Schedule. . . Floseal and distraction screws are supplies, not implants. They remain denied as This procedure is include in another procedure performed on this date. . . . Cervical disc prosthetic x 2 are now paid at cost + 10% per Fee Schedule. Copies of EOBs are attached for your review."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
February 27, 2017 to March 2, 2017	Inpatient Hospital Services	$33,814.05	$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 §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:
   - X045 – DRG CODE CONSIDERED INVALID BASED ON ONE OR MORE OF THE FOLLOWING. 1. INCORRECT DRG VERSION PER STATE FEE SCHEDULE GUIDELINES. 2. INCORRECT ASSIGNMENT OF ONE OR MORE ICD-9 DIAGNOSIS OR ICD-9 PROCEDURE CODES. 3. DOCUMENTATION FROM MEDICAL RECORDS DOES NOT SUPPORT CODE ASSIGNMENT OF BILLED DRG. PLEASE REVIEW AND SUBMIT CORRECTED BILLING FORM WITH REVISED DRG AND, OR DOCUMENTATION SUPPORTING DRG ASSIGNMENT.
   - X212 – THIS PROCEDURE IS INCLUDED IN ANOTHER PROCEDURE PERFORMED ON THIS DATE.

Issues

1. What is the recommended payment amount for the services in dispute?
2. What is the additional recommended payment for the implantable items in dispute?
3. Is the requestor entitled to additional payment?

Findings

1. This dispute regards Inpatient hospital facility services provided to an injured employee with payment subject to 28 Texas Administrative Code §134.404(f), which requires that the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount (including outlier payments) applying the effective Medicare Inpatient Prospective Payment System (IPPS) formulas and factors, published annually in the Federal Register, with modifications as set forth in the rule. Medicare IPPS formulas and factors are available from http://www.cms.gov.

   Review of the submitted documentation finds that separate reimbursement for implantables was requested.

   Rule §134.404(f)(1)(B) requires that, for these disputed services, the Medicare facility specific amount, including any outlier payment, be multiplied by 108 percent.

   Per Rule §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 Rule §134.404(g).

   The facility's total billed charges for the separately reimbursed implantable items are $65,000. Accordingly, the facility's total billed charges shall be reduced by this amount when calculating any outlier payment.

   Review of the submitted medical bill and supporting documentation finds that the DRG code assigned to the disputed services is 518. The services were provided at Pine Creek Medical Center in Dallas. Based on the submitted DRG code, the service location, and bill-specific information, the division determines that the Medicare facility specific amount is $16,540.79. This amount multiplied by 108% results in a MAR of $17,864.05.

2. 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-ons per admission.

   The respondent asserts, "distraction screws are supplies, not implants." Distraction screws are used with orthopedic retractors (distractors) for retracting vertebral bodies during surgical procedures. These screws are removed as part of the procedure and do not remain in the body after surgery. Moreover, the surgeon did not document the use of distraction screws in the operative report. Accordingly, the division finds the requestor has failed to support separate reimbursement of distraction screws with respect to the services in dispute. Payment is not recommended.

   Additionally, separate reimbursement was requested for "IMP FLOSEAL 10 ML," listed on the requestor's itemized statement as an implantable. However, review of the submitted materials finds no invoice to support separate payment of the Floseal. Reimbursement cannot be recommended.

   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 $65,000.00. Accordingly, the facility's total billed charges shall be reduced by this amount when calculating outlier payments.

Review of the submitted information finds the separately reimbursable implantable items include:

"DISC CERVICAL 13X15 H5 PROSTH" as identified in the itemized statement, labeled on the invoice as "MOBI-C IMPLANT M <STANDARD> 13X15 H5 US"

This item has a cost per unit of $6,500.00, at 2 units, for a total cost of $13,000.00.

The total net invoice amount (exclusive of rebates and discounts) is $13,000.00. 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 $1,300.00. The total recommended reimbursement amount for the implantable items is $14,300.00.

3. The total allowable reimbursement for the services in dispute is $32,164.05. This amount less the amount previously paid by the insurance carrier of $34,178.86 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the available evidence presented by the requestor and respondent at the time of review. Even though not all the evidence was discussed, it was considered.

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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	January 12, 2018
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 Rule §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. **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.