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 ORTHOPEDIC & SPINE HOSPITAL

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-18-2683-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 26, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The following claim was not processed according to Texas fee guidelines for inpatient services."

Amount in Dispute: $12,584.59

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor has not provided any explanation how the Medicare base payment amount for the hospital is $23,460.69."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
July 25, 2017 to July 26, 2017	Inpatient Hospital Services	$12,584.59	$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:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 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.
   - 468 – Reimbursement is based on the medical hospital inpatient prospective payment system methodology.
   - 774 – Implant provider charges denied per inpatient FG. Required certification not included per Rule 134.404(g)(1)

- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 420 – Supplemental payment.
- 897 – Separate reimbursement for implantables made in accordance with DWC Rule Chapter 134; Subchapter (E) Health Facility Fees

Issues

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

Findings

1. This dispute regards inpatient hospital facility services with payment subject to 28 Texas Administrative Code §134.404(f), requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount (including outlier payments) applying Medicare Inpatient Prospective Payment System (IPPS) formulas and factors, as published annually in the Federal Register, with modifications set forth in the rules. Medicare IPPS formulas and factors are available from the Centers for Medicare and Medicaid Services at 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 $4,300.00. Accordingly, the facility's total billed charges shall be reduced by this amount when calculating any outlier payment.

   The division calculates the Medicare facility specific amount using Medicare's *Inpatient PPS PC Pricer* as a tool to efficiently identify and apply IPPS formulas and factors. This software is freely available from www.cms.gov.

   Note: the "VBP adjustment" of $84.58 listed in the *PC Pricer* was removed in calculating the facility amount for this admission. Medicare's Value-Based Purchasing (VBP) program is an initiative to improve quality of care in the Medicare system. However, such programs conflict with Texas Labor Code sections 413.0511 and 413.0512 regarding review and monitoring of health care quality in the Texas workers' compensation system. Rule §134.404(d) requires that specific Labor Code provisions and division rules take precedence over conflicting CMS provisions for administering Medicare; therefore, VBP adjustments are not considered in determining the facility reimbursement.

   Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 470. The service location is Arlington, Texas. The division notes that discharge status code 06 in box 17 of the bill indicates the claim is subject to Medicare's post-acute transfer payment policy. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $9,254.73. This amount multiplied by 108% results in a MAR of $9,995.11.

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.

   Review of the submitted documentation finds the requestor submitted invoices and documentation to support $4,300.00 in implants. The total net invoice amount (exclusive of rebates and discounts) is $4,300.00. The total add-on amount of 10% is $430.00. The total recommended reimbursement is $4,730.00.

3. The total recommended payment for the claim is $14,725.11. Documentation supports the insurance carrier has paid $17,555.32. The amount remaining due to the requestor is $0.00. No additional payment is 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	April 13, 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.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.