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
OLD REPUBLIC INSURANCE COMPANY

MFDR Tracking Number
M4-18-3045-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
April 23, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Pine Creek Medical Center remains under paid for the implants."

Amount in Dispute: $50,685.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider is billing for items that were not permanently implanted and for items that do not meet the definition of implants, as defined in 28 TAC §134.404(b)(2)."

Response Submitted by: ForeSight Medical, LLC

SUMMARY OF FINDINGS

Date of Service	Disputed Services	Dispute Amount	Amount Due
October 25, 2017	Inpatient Hospital - Revenue Code 278 Implants	$50,685.00	$46,650.00.

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 hospital facility fee guideline for inpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - 6981 – Charges for surgical implants are reviewed separately by ForeSight Medical.
   - OA – The amount adjusted is due to bundling or unbundling of services.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 1014 - The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
   - 10 – Upon review of submitted request for reconsideration, ForeSight has determined that no additional allowance will be made.
   - 14 – This item was determined to not have been permanently implanted during the procedure.
   - 2 – Device payment was based on documentation provided by your facility.

Issues

Is the requestor entitled to additional payment?

Findings

This dispute regards items billed under revenue code 278 for which separate reimbursement was requested. Payment is subject to the division's *Hospital Facility Fee Guideline—Inpatient*, Rule §134.404(g) which requires that implantables are reimbursed at the lesser of the invoice amount or net amount (exclusive of rebates and discounts) plus 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-ons per admission.

The insurance carrier denied payment stating that the items in dispute "were placed into the patient and removed from the patient … during the same inpatient stay and were determined not to be eligible for payment since they were not permanently implanted." The division finds no such requirement in applicable Rule §134.404. For that reason, the carrier's denial reason is not supported.

Accordingly, separate payment is recommended as follows:

Hospital Itemized Statement				Cost Invoices			Add-on
3300I26207	Cable Spectra 2FT 2x8 w/ Ext	2	$6,720	2x8 OR Cable and extension	Item 0040 Item 0050	$600 x 2 = $1,200	Lesser of Cost +10% or $1,000 per item BUT not to exceed $2,000 total add-on. Rule 134.404(g)
3300I34446	Imp Floseal 10ML Hemo Matrix	1	$1,855	Unsupported - NO COST INVOICE		$0.00	
3300I12103	Lead Ext Phase III 25cm	4	$20,200	Lead Extension Kit 25 CM	Item 0070 Item 0080 Item 0090 Item 0010	$1,010 x 4 = $4,040	
3300I33452	Lead Coveredge 32 Kit 70cm	1	$55,625	Coverage 32 Surgical Lead Kit 70 CM	Item 0030	$11,125	
3300I26965	IFG Spectra (Gen Only)	1	$141,425	Precision Spectra IFG Kit	Item 0060	$28,285	
3300I12209	Imp Duragen Plus 3x3"	1	$6,595	Unsupported - NO COST INVOICE		$0.00	
3300I17259	Imp Duraseal 5ml	1	$6,285	Unsupported - NO COST INVOICE		$0.00	
3300I07986	Imp Floseal 5ml	2	$2,060	Unsupported - NO COST INVOICE		$0.00	
		13	**$240,765**		**Cost + Add-on =**	**$44,650.00**	**$2,000.00**
					Total Payment =	**$46,650.00**	

The total payment amount detailed above 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 findings in this decision are based on the evidence available 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 established that additional payment is due. As a result, the amount ordered is $46,650.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $46,650.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		May 17, 2019
Signature	Medical Fee Dispute Resolution Officer	Date
	Martha Luévano	May 17, 2019
Signature	Director of Medical Fee Dispute Resolution	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.