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
TEXAS HEALTH CENTER FOR DIAGNOSTICS & SURGERY - PLANO

Respondent Name
EMPLOYERS INSURANCE COMPANY OF WAUSAU

MFDR Tracking Number
M4-18-3159-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
April 30, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are requesting reimbursement for implants. The carrier has paid the DRG correctly for the impatient [sic] stay but denied our reconsideration request for implants."

Amount in Dispute: $3,756.52

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The products Surgiflo and Surgicel are hemostatic agents used to control bleeding and are not considered an implantable device."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
February 9, 2018 to February 10, 2018	Inpatient Hospital Facility Services	$3,756.52	$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 hospital facility fee guideline for inpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 45 – [NO DESCRIPTION FOR THIS CODE WAS FOUND WITH THE SUBMITTED MATERIALS.]
   - Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
   - P300 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
   - Z695 – THE CHARGES FOR THIS HOSPITALIZATION HAVE BEEN REDUCED BASED ON THE FEE SCHEDULE ALLOWANCE.
   - X212 – THIS PROCEDURE IS INCLUDED IN ANOTHER PROCEDURE PERFORMED ON THIS DATE.

- 97 – [NO DESCRIPTION FOR THIS CODE WAS FOUND WITH THE SUBMITTED MATERIALS.]
- 193 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
- B13 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
- W3 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCH

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 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 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.

   Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 518. The service location is Plano, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $17,450.86. This amount multiplied by 108% results in a MAR of $18,846.93.

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 following implantables:
   - "SUPERIOR END PLATE" as labeled on the invoice, with a cost per unit of $5,000.00;
   - "INFERIOR END PLATE" as labeled on the invoice, with a cost per unit of $5,000.00;
   - "POLYETHYLENE INLAY" as labeled on the invoice, with a cost per unit of $1,000.00.

   Additionally, the health care provider billed for "SURGIFLO MATRIX" and "HEMOSTAT SURGICEL ABSORBABLE 4X8," as labeled on the invoices.

   The respondent asserts, "The products Surgiflo and Surgicel are hemostatic agents used to control bleeding and are not considered an implantable device."

   Per §134.404(b)(2), "Implantable" means an object or device that is surgically: (A) implanted, (B) embedded, (C) inserted, (D) or otherwise applied, and (E) related equipment necessary to operate, program and recharge the implantable. Review of the submitted documentation finds insufficient documentation to support that this item was implanted or meets the definition of an implantable under §134.403(b)(2). Separate reimbursement is not recommended.

   The requestor did not discuss, explain, or provide any information to support how the disputed items meet the definition of implantable in Rule §§134.404(b)(2). Based on the preponderance of evidence, the division finds the requestor has failed to support any additional reimbursement is due for the disputed items.

The total net invoice amount (exclusive of rebates and discounts) for the supported implantables is $11,000.00.
The total add-on amount of 10% or $1,000 per billed item add-on (whichever is less) is $1,100.00.
The total recommended reimbursement amount for the implantable items is $12,100.00.

3. The MAR for the hospital facility services is $18,846.93. The separate reimbursement for the supported implantable items is $12,100.00. The total recommended payment for the services in dispute is $30,946.93. The insurance carrier has paid $30,946.93, leaving an amount due to the requestor of $0.00. No additional reimbursement 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

Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	May 17, 2018 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.