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
Saint Camillus Medical Center

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-18-5090-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 21, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to the Explanation of Benefits dated 07/09/18, we were paid a total of $93,717.41 for Inpatient services totaling $468,939.73. However, it appears that our facility was not reimbursed for implants separately as requested on the UB04."

Amount in Dispute: $10,329.61

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requester has no shown why $10,329.61 is due."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 31, 2018 through June 2, 2018	Inpatient Hospital Services	$10,329.61	$10,329.61

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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
   - 468 Reimbursement is based on the medical hospital inpatient prospective payment system methodology

- 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 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 reimbursement?

Findings

1. The insurance carrier reduced the inpatient hospital services rendered from May 31, 2018 through June 2, 2018 with claim adjustment reason code P12 – "Worker's compensation jurisdictional fee schedule adjustment."

   28 Texas Administrative Code §134.404 (f) states,

   > 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.

   Review of the submitted documentation finds that separate reimbursement for implantables was requested; for that reason, the MAR is calculated according to §134.404(f)(1)(B) found below.

Per §134.404(f)(1)(B), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment by 108%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Review of the submitted documentation finds that the DRG code assigned to the services in dispute is 455. The services were provided at Saint Camillus Medical Center. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $65,622.69. This amount multiplied by 108% results in a MAR of $70,872.51.

2. Additionally, the provider requested separate reimbursement of implantables. Per §134.404(g):

   > Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be 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-on's per admission.

   Review of the submitted documentation finds that the separate implantables include:

   - Sterifuse DBM putty 10
   - Lateral interbody cage 10x50mm
   - Lateral interbody cage 10 x 50mm
   - Pedicle screw (6)
   - set screw (6)
   - curved rod 100m (2)

The total net invoice amount (exclusive of rebates and discounts) is $60,645.00. 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 $2,000.00. The total recommended reimbursement amount for the implantable items is $62,645.00.

3. The total allowable is $133,517.51. The amount previously paid by the insurance carrier is $93,717.41. The requestor is seeking $10,329.61. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $10,329.61.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $10,329.61 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 19, 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 28 Texas Administrative Code §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 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.