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
LIBERTY MUTUAL FIRE INSURANCE COMPANY

MFDR Tracking Number
M4-19-0860-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
October 16, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Manufacture Implant cost is $9,013.50 plus mark of $901.39 = Total amount due $9,914.89."

Amount in Dispute: $5,691.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "A re-review has been completed and the total TX IP FS allowance = $22,442.59 … Of note, the fluted headless pin was disallowed as not implanted."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
May 7, 2018 to May 10, 2018	Inpatient hospital surgery with implants	$5,691.60	$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:
   - 309 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
   - 243 – THE CHARGE FOR THIS PROCEDURE WAS NOT PAID SINCE THE VALUE OF THIS PROCEDURE IS INCLUDED/BUNDLED WITHIN THE VALUE OF ANOTHER PROCEDURE PERFORMED.
   - 876 – FEE SCHEDULE AMOUNT IS EQUAL TO THE CHARGE.
   - B13 - THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
   - Z710 - THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
   - P300 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
   - X212 – THIS PROCEDURE IS INCLUDED IN ANOTHER PROCEDURE PERFORMED ON THIS DATE.
   - X023 – PAYMENT FOR CHARGE IS NOT RECOMMENDED WITHOUT AN INVOICE OR DOCUMENTATION OF COST. FOR RECONSIDERATION PLEASE SUBMIT APPEAL WITH EOP AND DOCUMENTATION OF COST AND OR ATTESTATION STATEMENT OF COST AS REQUIRED BY STATE FEE SCHEDULE GUIDELINES.

- W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

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 payment?

Findings

1. This dispute regards inpatient services with payment subject to the *Hospital Facility Fee Guideline—Inpatient*, Rule §134.404, 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 published in the Federal Register, with modifications set out in the rule. Medicare IPPS formulas and factors are available from the Centers for Medicare and Medicaid Services at http://www.cms.gov.

   The hospital requested separate reimbursement for implantables; accordingly, Rule §134.404(f)(1)(B) requires that reimbursement shall be the Medicare facility specific amount, including any outlier payment, multiplied by 108%.

   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 $42,859.50. 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 also freely available from www.cms.gov.

   Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 470. Box 17 on the bill has patient status code 6, indicating the bill is subject to Medicare payment policy regarding post-acute transfers. The service location is Saint Camillus Medical Center, Hurst, Texas. Based on the DRG code, service location, and bill-specific information, the Medicare facility specific amount is $12,013.28. This amount multiplied by 108% results in a MAR of $12,974.34.

2. Additionally, the provider requested separate reimbursement of implantables. Per Rule §134.404(g), when billed separately in accordance with subsection (f)(1)(B), 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, whichever is less, but not to exceed $2,000 in add-ons per admission.

   Review of the submitted documentation finds the following implantables:

   - "IMP STRY PATELLA S36X10MM" as identified in the itemized statement and labeled on the invoice as "TRIATHLON SYMMETRIC X3 PATELLA" with a cost per unit of $863.00;
   - "POSTERIOR STABILIZED FEMORAL" as identified in the itemized statement and labeled on the invoice as "TRIATHLON PS FEM COMPONENT CEMENTED" with a cost per unit of $2,527.50;
   - "TIBIAL INSERT 6 11 MM" as identified in the itemized statement and labeled on the invoice as "TRIATHLON X3 TIBIAL INSERT" with a cost per unit of $1,793.00;
   - "TIBIAL BASE PLATE" as identified in the itemized statement and labeled on the invoice as "TRI TS BASEPLATE SIZE 6" with a cost per unit of $2,201.00;
   - "IMP CEMNT STRY W/TOBRAMYCIN" as identified in the itemized statement, labeled on the invoice "SIMPLEX P WITH TOBRAMYCIN 10 PACK" with a cost per unit of $611.50 at 2 units, for a total cost of $1,223.00.

   Note: the health care provider billed for and provided invoice documentation for the following item.

   - "IMP STRY PIN PACK HEADLSS 1/8"" as identified in the itemized statement and labeled on the invoice as "STERILE FLUTED HEADLESS 1/8" PIN 3.5" Long" with a cost per unit of $442.00;

   However, the carrier maintains this item "was disallowed as not implanted." Review of the operative report finds the provider failed to document this item was used in the surgery. Accordingly, reimbursement for the sterile fluted headless 1/8 pin cannot be recommended.

The total net invoice amount (exclusive of rebates and discounts) is $8,607.50. 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 $860.75. The total recommended reimbursement amount for the implantable items is $9,468.25.

3. The total allowable reimbursement for the services in dispute is $22,442.59. The insurance carrier paid a total of $22,442.59, plus an additional interest payment of $44.50. The amount due to the requestor is $0.00. Accordingly, 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 emphasizes that the findings in this decision are based on the evidence presented by the requestor and respondent 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 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	November 20, 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 division must receive the request within twenty days of your receipt of this decision. The request may be faxed, mailed or personally delivered either to the division, using the contact information listed on the form, or to the field office handling the claim.

The party seeking review must deliver a copy of the request to all parties involved in the dispute at the same time the request is filed. Include a copy of this *Medical Fee Dispute Resolution Findings and Decision* together with any other information required by 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.