TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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# AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Texas Institute for Surgery

**Respondent Name**
Hartford Accident & Indemnity Co

**MFDR Tracking Number**
M4-19-3342

**Carrier's Austin Representative**
Box Number 47

**MFDR Date Received**
March 4, 2019

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The claim was originally submitted to The Hartford on 11/29/2018 with separate reimbursement requested for implants. …The Hartford underpaid this claim and refused to pay additional amount due upon appeal."

**Amount in Dispute:** $54,943.83

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Dates of service in dispute were processed in accordance with Texas Workers' Compensation Guidelines, Rules 134.404."

**Response Submitted by:** The Hartford

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| October 30, 2018 through November 6, 2018 | Inpatient Hospital Services | $54,943.83 | $0.00 |

## *AMENDED FINDINGS AND DECISION*

By Official Order Number 2807 dated October 17, 2013, the undersigned has been delegated authority by the Commissioner to **amend** fee dispute decisions.

This **amended** findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent.

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:
   - 197 – Recommended allowance based on negotiated discount/rate
   - 131 – Claim specific negotiated discount
   - 4458 – Foresight – charges for surgical implants are reviewed separately by foresight medical
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 4896 – Payment made per Medicare's IPPS methodology, with the applicable state markup

**Issues**

1. Did the insurance carrier's support reduction of payment for disputed services?
2. What is the applicable rule for determining reimbursement of the disputed services?
3. What is the additional recommended payment for the implantable items in dispute?
4. Is the requestor entitled to additional reimbursement?

**Findings**

1. This dispute relates to medical services provided in an inpatient acute care hospital. The insurance carrier reduced the disputed services based on "negotiated discount/rate". Insufficient documentation was found to support that the services are subject to a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011. Reimbursement is therefore subject to the provisions of 28 Texas Administrative Code §134.404(f), which states that:

   > The reimbursement calculation used for establishing the MAR [maximum allowable reimbursement] 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.
   >
   > (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 subsection (g) of this section.

   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).

2. Per §134.404(f)(1)(B), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment by 108%. Per §134.404(f)(2) "the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under subsection (g)." The total charges for implantables reimbursed under subsection (g) is $179,967.00. This amount will be deducted from the total billed charge amount of $279,293.55. 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 454. The services were provided at Texas Institute for Surgery. Based on the submitted DRG code, the service location, total non-implantable billed charges of $99,326.55, and bill specific information the Medicare facility specific amount is $37,043.72. This amount multiplied by 108% results in a MAR of $40,007.22.

3. 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:

- Medtronic infuse bmp medium 7510400, 1 unit - supported by invoice
- Medtronic infuse bmp small 7510200, 1 unit - supported by invoice
- Cage 35x25x14mm 13 deg, 1 unit – supported by invoice
- Plate anterior buttress 23mm, 1 unit – supported by invoice
- screw anterior buttress 6x25mm, 1 unit – supported by invoice
- Autologous Medtronic Autolog, 1 unit - supported by invoice
- Cage 35x25.12mm 13 deg, 1 unit – supported by invoice
- Screw Alif VA 5.5x25mm, 4 units – supported by invoice
- Plate lck Alif 50mm rad, 1 unit – supported by invoice
- Screw Pedicle cann 6x40mm, 4 units – supported by invoice
- Screw Pedical cann 7x35mm, 2 units – supported by invoice
- Set Screw Flat Lock, 6 units, - **ONLY** 4 units supported by invoice
- Rod Bullett pre-bent, 2 units, - **NOT** supported by invoice
- Autologous Medtronic Autolog, 1 unit, - supported by invoice

The total net invoice amount (exclusive of rebates and discounts) is $42,835.20. 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 for which the cost was supported by an invoice is $44,835.20.

4. The total recommended payment for the services in dispute is the Medicare facility specific amount of $40,007.22 plus the implantable reimbursement of $44,835.20 equals $84,842.42. The insurance carrier previously paid $87,245.72. No additional payment is recommended.

**Conclusion**

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**

| | | |
|---|---|---|
| | | May 1, 2019 |
| Signature | Medical Fee Dispute Resolution Officer | Date |
| | | May 1, 2019 |
| Signature | Director for 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 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**.