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
Crescent Medical Center

Respondent Name
Liberty Mutual Fire Insurance Co

MFDR Tracking Number
M4-19-4519-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
June 17, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 6/29/2018 the patient returned to our Emergency Room with a surgical site infection and the patient was admitted. On 7/13/18 our registration clerk spoke with the adjuster on file and was told no auth was need for this visit, because it was emergent."

Amount in Dispute: $43,295.63

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Denied bill as valid DRG number required for review. Please re-submit bill with proper information for further processing. See attached Clinical Coding Expert pricing sheet supporting DRG 517. Provider never submitted corrected billing for DRG."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 29 – July 8, 2018	DRG 857	$43,295.63	$32,312.28

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 reimbursement guidelines for inpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 5917 – Pre-authorization was required, but not requested for this service, per DWC Rule 134.600

- 185 – Valid DRG and/or Medicare number required for review. Please resubmit with proper information for further processing

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to additional payment?

Findings

1. The requestor is seeking reimbursement for inpatient hospital services rendered from June 29 to July 7, 2018. The insurance carrier denied the services based on lack of preauthorization and invalid DRG.

   28 TAC §134.600 (p) states in pertinent part **Non-emergency** health care requiring preauthorization includes inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay.

   28 TAC §133.2 (5) defines a medical emergency as the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health or bodily functions in serious jeopardy.

   Review of the admission record found the patient presented with an emergent condition. The insurance carrier's denial for lack of pre-authorization is not supported.

   The submitted medical bill contained DRG 857 which is defined as postoperative or post traumatic infection with operative procedure.

   Review of the submitted admission record supports the admission and subsequent services met this description.

   The disputed claim will be reviewed based on the information submitted on the medical bill found below.

2. 28 TAC §134.404(f), requires 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.

   Separate reimbursement for implants was requested. The provisions of TAC §134.404(f)(1)(B) allows the Medicare facility specific amount to be multiplied by 108 percent.

   The division calculates the Medicare facility specific amount by 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.

3. Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 857. The service location is Lancaster, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $14,101.28. This amount multiplied by 108% results in a MAR of $15,229.38.

   28 TAC §134.404(g) requires implants billed separately by the facility 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.

   The submitted document contained documents that indicate the implants were as follows:

Item Name from Itemized Statement	Item Name from Invoice	Implantable Billed Price	Cost/Unit	# Units	Total Cost	10% Not to Exceed $1000	Total Allowed Per Implantable
Screw set small	T-30 Set screw, 9.5mm	$950.00	$95.00	2	$190.00	$19.00	$209.00
Screw set	T-30 Set screws 11.00mm	$950.00	$95.00	2	$190.00	$19.00	$209.00
Connectors offset	Open Iliac Connector	$10,000.00	$1,000.00	2	$2,000.00	$200.00	$2,200.00
Screw 90mm TI	Ti Polyaxial Screw 90mm	$4,300.00	$860.00	1	$860.00	$86.00	$946.00
Screw 80mm TI FLLIAC	Ti Polyaxial Screw 80mm	$4,300.00	$830.00	1	$830.00	$83.00	$913.00
Cap screw	Fortex cap	$11,850.00	$395.00	6	$2,370.00	$237.00	$2,607.00
Rod 100mm	100mm cont radius rod	$3,950.00	$395.00	2	$790.00	$79.00	$869.00
Bone Matrix	Viable bone matrix	$41,500.00	$4,150.00	2	$8,300.00	$830.00	$9,130.00
		$77,800.00			$15,530.00	$1,553.00	$17,083.00

The facility's total billed charges for the separately reimbursed implantable items was $77,800.00. The total net invoice amount is $15,530.00. The total add-on amount is $1,553.00.

The total recommended reimbursement amount for the implantable items is $17,083.00.

4. The total adjusted allowable (total of medical bill less the billed amount for implants) for the services per the applicable IPPS pricer is $14,101.28. This amount multiplied by 108% = $15,229.38. This amount is added to the total add-on amount of $17,083.00 for a total of $32,312.28. This amount 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 $32,312.28.

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 $32,312.28, 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	December 6, 2019 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, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.