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
MARKEL INSURANCE COMPANY

MFDR Tracking Number
M4-19-4976-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
July 22, 2019

Response Submitted By
Downs Stanford, P.C. and Rising Medical Solutions

REQUESTOR'S POSITION SUMMARY

"An additional payment of $11,884.96 is due on the DRG (copy of IPPS Pricer attached for your review.)"

RESPONDENT'S POSITION SUMMARY

"Respondent stands by the original payment for the service in dispute"

"The nurse auditor did not include an allowance for the 10cc sterifuse putty and floseal adapter because neither of these implants were supported by the operative report."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
January 7, 2019	Inpatient Hospital Services	$11,884.96	$434.50

AUTHORITY

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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:
   - 353 – THIS CHARGE WAS REVIEWED PER THE ATTACHED INVOICE.
   - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.
   - 687 – THIS SERVICE WAS REIMBURSED ACCORDING TO THE MEDICARE TRANSFER POLICY UNDER THE INPATIENT PROSPECTIVE PAYMENT SYSTEM.
   - 350 – BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

Is the requestor entitled to additional payment?

Findings

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 with modifications set out in the rule. Medicare IPPS formulas and factors are available from 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 $60,975.00. 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 460. The service location is Hurst, Texas. The discharge status code is 66, which indicates a short-term acute transfer. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $16,662.63. This amount multiplied by 108% results in a MAR of $17,995.64.

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:

- "6.5X45MM PEDICLE SCREW" as identified in the itemized statement with a cost per unit of $1,495.00;
- "6.5X40MM PEDICLE SCREW" as identified in the itemized statement with a cost per unit of $1,495.00;
- "SET SCREW" as identified in the itemized statement with a cost per unit of $395.00 at 2 units, for a total cost of $790.00;
- "9X29X9* PLIF CAGE" as identified in the itemized statement with a cost per unit of $8,000.00;
- "45MM CURVED ROD" as identified in the itemized statement with a cost per unit of $395.00.

The division notes that invoices were found for Floseal and Sterifuse Crunch Putty; however, the operative report did not support that these items were implanted.

The total net invoice amount (exclusive of rebates and discounts) is $12,175.00. 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 $1,217.50. The total recommended reimbursement amount for the implantable items is $13,392.50.

The MAR for services of $17,995.64 plus the separate reimbursement of $13,392.50 for implants results in a total recommended payment of $31,388.14. This amount less the amount previously paid by the insurance carrier of $30,953.64 leaves an amount due to the requestor of $434.50. This amount 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 findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above, the division finds that additional payment is due. As a result, the amount ordered is $434.50.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable), based on the submitted information, the division finds the requestor is entitled to additional reimbursement. The division hereby ORDERS the respondent to remit to the requestor $434.50, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	August 16, 2019
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.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). 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 field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute 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.