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
Texas Health Rockwall

Respondent Name
Property & Casualty Ins Co of Hartford

MFDR Tracking Number
M4-20-0326-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
October 3, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Separate implant reimbursement was requested and paid however, there is outstanding balance in the amount of 13802.68…."

Amount in Dispute: $13,802.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Dates of service in dispute were processed in accordance with Texas Workers' Compensation Guidelines, 28 TAC §134.404."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 14 – 15, 2019	Inpatient Hospital Services	$13,802.68	$0.00

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
   - 4896 – Payment made per Medicare's IPPS methodology, with the applicable state markup

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

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

Findings

1. This dispute relates to facility medical services provided in an inpatient acute care hospital on May 14 – 15, 2019. The insurance carrier reduced the disputed services based on the workers compensation division fee schedule.

   28 TAC §134.404 (d) requires Texas workers' compensation system participants to apply Medicare payment policies for coding, billing, reporting, and reimbursement of health care covered in this section in effect on the date a service is provided. The applicable calculation based on the Medicare payment policies and Division fee guideline is shown below.

2. Reimbursement is per 28 TAC §134.404(f), the Medicare facility specific amount which is 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 sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount will be multiplied by 143 percent without separate request for implants or 108 percent when separate reimbursement for implants is requested.

   Review of the submitted medical bill found separate reimbursement for implantables was requested. The MAR will be calculated by 108 percent.

3. The Medicare payment policy regarding 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 473. The services were provided at Texas Health Rockwall. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $13,995.77. This amount multiplied by 108% results in a MAR of $15,115.43.

   The submitted itemized statement finds that the separate implantables include:

   - 1 Bone Block 12mm billed amount $2,050, cost $500.00. Total allowable $550.00
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   - 1 Putty DMB 2.5cc billed amount $1,025.00, cost $250.00. Total allowable $275.00
   - 1 Cage Calix Lordotic 11 x 14 x 7mm billed amount $3,280.00, cost $800.00. Total allowable $880.00
   - 1 Cage Calix Lordotic 11 x 14 x 8mm billed amount $3,280.00, cost $800.00. Total allowable $880.00
   - 1 Plate Cervical 30mm billed amount $3,280.00, cost $800.00. Total allowable $880.00
   - 6 Screw self-drilling 4.0 billed amount $3,690.00, cost $900.00. Total allowable $990.00

   The total net invoice amount $4,550.00. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less is $455.00.

   The total recommended reimbursement amount for the implantable items is $5,005.00.

4. The total recommended payment for the services in dispute is $20,120.43. The insurance carrier paid $20,120.43. No additional payment is recommended.

Conclusion

For the reasons stated above, DWC finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, DWC has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		October 23, 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 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.