TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TX HEALTH ROCKWALL

Respondent Name
TASB RISK MANAGEMENT FUND

MFDR Tracking Number
M4-20-0354-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
October 8, 2019

Response Submitted By
TASB Risk Management Fund

REQUESTOR'S POSITION SUMMARY

"This is an inpatient claim where separate reimbursement for implants was requested. Per the EOB received, no reimbursement for implants was issued."

RESPONDENT'S POSITION SUMMARY

"The Fund has made total payments of 17,537.07 based on the maximum allowable reimbursement as per the IPPS fee guideline…"

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
December 20, 2018 to December 23, 2018	Inpatient Hospital Services	$128.04	$0.00

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 (DWC) in Title 28, Part 2 of the Texas Administrative Code.

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:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - W3 – Additional payment made on appeal/reconsideration.
   - 193 – Original payment decision is being maintained. Upon review, it was det

Issues

Is the requestor entitled to additional payment?

Findings

This dispute regards inpatient services with payment subject to the *Hospital Facility Fee Guideline—Inpatient*, 28 Texas Administrative Code §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 $21,066.00. Accordingly, the facility's total billed charges shall be reduced by this amount when calculating any outlier payment.

DWC 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.

Note: the "VBP adjustment" listed in the *PC Pricer* was removed in calculating the facility amount for this admission. Medicare's Value-Based Purchasing (VBP) program is an initiative to improve quality of care in the Medicare system. However, such programs conflict with Texas Labor Code sections 413.0511 and 413.0512 regarding review and monitoring of health care quality in the Texas workers' compensation system. Rule §134.404(d)(1) requires that specific Labor Code provisions and division rules take precedence over conflicting CMS provisions for administering Medicare. Consequently, VBP adjustments are not considered in determining the facility reimbursement.

Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 470. The service location is Rockwall, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $11,678.09. This amount multiplied by 108% results in a MAR of $12,612.34.

Additionally, the provider requested separate reimbursement of implantables. Per 28 TAC §134.404(g):

> Implantables, when billed separately by the facility … 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 the following implants:

- "SHELL 54MM" with a cost per unit of $1,040.00;
- "SCREW CANC 6.5MM 25MM" with a cost per unit of $650.00;
- "LINER ACETABULAR 36MM" with a cost per unit of $1,040.00;
- "FEMORAL COMPONENT SIZE 8" with a cost per unit of $650.00;
- "FEMORAL HEAD TAPER 12/14 36MM" with a cost per unit of $1,040.00.

The total net invoice amount (exclusive of rebates and discounts) is $4,420.00. 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 $442.00. The total recommended reimbursement amount for the implantable items is $4,862.00.

The total allowable reimbursement for the services in dispute is $17,474.34. This amount less the amount previously paid by the insurance carrier of $17,537.07 leaves an amount due to the requestor of $0.00. No additional reimbursement is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of the division is to adjudicate payment following Texas laws and DWC 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 requestor has not established that additional payment is due. As a result, the amount ordered is $0.00.

ORDER

In accordance with Texas Labor Code §413.031, based on the information submitted for review, DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	October 31, 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 TAC §133.307.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). DWC must receive the request within twenty days of your receipt of this decision.

You may fax, mail or personally deliver the request to either the field office handling the claim or to DWC at the contact information on the form. You must send a copy to all other parties in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** along with any other information required by 28 TAC §141.1(d).

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