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
South Texas Spine & Surgical

Respondent Name
Insurance Co of the State of PA

MFDR Tracking Number
M4-20-1207-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 13, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has yet to respond with payment or denial except for Foresight who has paid for implants only."

Amount in Dispute: $21,415.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: None submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 5 – 7, 2019	Inpatient Hospital Services	$21,415.85	$21,059.80

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:
   - 2 – Device payment was based on documentation provided by your facility

Issues

1. What is the applicable rule for determining reimbursement of the disputed services?
2. What is the recommended payment for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of impatient hospital services rendered from April 5 – 7, 2019.

   28 TAC §134.404(f) states the maximum allowable reimbursement is the Medicare facility specific amount is determined by applying the most recently adopted and effective Medicare 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.

   When separate reimbursement of implants is not requested, the Medicare facility specific amount is multiplied by 143 percent. When separate reimbursement for implants is made the Medicare facility specific reimbursement is multiplied by 108 percent.

Billed charges	Implant charge	Amount entered into PPS Pricer	Total DRG payment	Multiplied by 108%
$93,294.92	$63,160.00	$30,134.92	$15,479.21	$16,717.55

   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.

2. The provider requested separate reimbursement of implants that include:
   - Compressible Strip Sponge XL (2)
   - Set Screw (4)
   - Rod 50mm (2)
   - Impl Screw 3.5x12
   - Impl Screw 3.5x20mm (2)
   - Impl Screw 3.5x10mm(1)

   The total recommended amount for the implants is $17,369.00

3. The total recommended payment for the services in dispute is $34,086.55. This amount less the amount previously paid by the insurance carrier of $ 13,026.75 leaves an amount due to the requestor of $21,059.80. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $21,059.80.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $21,059.80 plus applicable accrued interest per 28 TAC §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		March 12, 2020
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, 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 with DWC. **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.