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
Texas Institute for Surgery

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-20-1542-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
February 18, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…payment for services provided to the above referenced patient does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code."

Amount in Dispute: $8,224.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: None submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 16 -17, 2019	Inpatient Hospital Services	$8,224.20	$7,917.42

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
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 790 – This charge was reimbursed in accordance to the Texas Medical fee guideline

- 897 – Separate reimbursement for implantables made in accordance with DWC Rule Chapter 134; Subchapter (e) Health Facility Fees
- 420- Supplemental payment

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. What is the additional recommended payment for the implantable items in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute relates to facility medical services provided in an inpatient acute care hospital reimbursement subject to the provisions of 28 TAC §134.404(f), which states that the reimbursement calculation used for establishing the MAR [maximum allowable reimbursement] shall be the Medicare facility specific amount, including outlier payment amounts, 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 submitted bill included a separate request for implants. When a provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent.

   Review of the submitted documentation finds that separate reimbursement for implantables was requested; for that reason, the MAR is calculated according to §134.404(f)(1)(B)(2) which requires the facilities billed charges be reduced by the charge for implants.

2. Per §134.404(f)(1)(B), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment by 108%. Information regarding the calculation of Medicare 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 483. The services were provided at Texas Institute for Surgery, Dallas, Texas. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $13,933.49. This amount multiplied by 108% results in a MAR of $15,048.17.

3. The provider requested separate reimbursement of implantables. Per §134.404(g) 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-on's per admission.

   Review of the submitted documentation finds that the separate implantables include:

   - Universe Revers Apex System Size 12
   - Univers Revers Suture Cup, 42
   - Humeral Insert L/42+3
   - 28mm Baseplate
   - 30mm Central Screw
   - 5.5x16mm peripheral screw (3)
   - 5.5x32mm peripheral screw, locking
   - 42 + 4 LAT/28 Glenosphere
   - Pin set, modular glenoid system

The total net invoice amount (exclusive of rebates and discounts) is $13,872.00. 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 $1,387.20. The total recommended reimbursement amount for the implantable items is $15,259.20.

4. The total recommended payment for the services in dispute is $30,307.37. This amount less the amount previously paid by the insurance carrier of $22,389.95 leaves an amount due to the requestor of $7,917.42. 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 $7,917.42.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), 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 $7,917.42 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		April 30, 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 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 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.