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
Surgery Specialty Hospitals

Respondent Name
United Airlines Inc

MFDR Tracking Number
M4-21-1248-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
March 24, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Carrier did not make payment according to the Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula. The sum of the Medicare facility specific reimbursement amount shall be multiplied by 108% plus implants at cost plus 10%."

Amount in Dispute: $1,469.39

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent has correctly reimbursed Requestor for the DRG 455 plus implatables {sic}. Enclosed please find a supplemental response from Foresight detailing the amount and reason for the reduction of the implantables billed at $72,039.00."

Response Submitted by: Downs Stanford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 12 – 14, 2020	Inpatient Hospital Services	$1,469.39	$868.44

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:
   - 468 – Reimbursement is based on the medical hospital inpatient prospective payment system methodology.
   - DY8 – Implant charges processed under separate cover through Foresight.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 14 – This item was determined to not have been permanently implanted during the procedure.
   - 4 – This item was determined to be a supply/non-implantable item.
   - P13 – Payment reduce or denied based on workers' compensation jurisdictional regulations or payment policies.

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 regards inpatient hospital facility services with payment subject to 28 TAC §134.404(f), 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, as published annually in the Federal Register, with modifications set forth in the rules. Medicare IPPS formulas and factors are available from the Centers for Medicare and Medicaid Services at http://www.cms.gov.

   Review of the submitted documentation finds that separate reimbursement for implantables was requested.

   Rule §134.404(f)(1)(B) requires that, for these disputed services, the Medicare facility specific amount, including any outlier payment, be multiplied by 108 percent.

   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 total amount billed was $234,390.75 this amount is reduced by the billed implant charges of $72,039.00 which makes the billed amount $162,351.75.

   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 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 documentation finds that separate reimbursement for implantables was requested; for that reason, the MAR is calculated according to §134.404(f)(1)(B) and is found below.

2. Per §134.404(g) implants when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, 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 that the separate implants requested include:

Item name from itemized statement	Item name from invoice	Implant billed price	Cost/unit	Units	Total Cost	10% not to exceed $1000	Total allowed per implant
Wax, Bone	Bone wax	$19.00	$57.39	1	See below		
Aquamantys Vein Seal	Bipolar Sealer	$2,060.00	$596.17	1	See below		
Putty DMB 10cc	AlloFuse DBM Putty 10cc	$3,960.00	$1,011.00	1	$1,011.00	$101.10	$1,111.00
Screw set	Savannah-T Set Screw	$5,600.00	$280.00	5	$1,400.00	$140.00	$1,540.00
Rod curved 5.5x35mm	Savannah-T Cruved Rod 45mm and 60mm	$6,400.00	$800.00	2	$1,600.00	$160.00	$1,760.00
Screw pedical 6x45mm	Pedicle screw w/grip quick threads, cortical cancellous	$24,000.00	$1,000.00	6	$6,000.00	$600.00	$6,600.00
Varlift LX H:11mm x 24 mml	VariLift-LX	$30,000.00	$5,000.00	2	$10,000.00	$1,000.00	$11,000.00
Total		$72,039.00		18	$20,011.00	$2,000.00 per rule	$22,011.00

Per 28 TAC §134.404(b)(2), "Implantable" means an object or device that is surgically:

(A) implanted,
(B) embedded,
(C) inserted,
(D) or otherwise applied, and
(E) related equipment necessary to operate, program and recharge the implantable.

The requestor indicated bone wax and Aquamantys vein seal were separately reimbursable as an implant. The insurance carrier (Foresight) indicated these items do not meet the definition of an implant as described above. Review of the submitted documentation found the insurance carrier's denial is supported.

3. Review of the submitted documentation finds that the DRG code assigned to the services in dispute is 455. The services were provided in Pasadena, Texas. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $30,175.08. This amount multiplied by 108% results in a MAR of $32,589.09. The recommended implant reimbursement is $22,011.00.

4. The total recommended payment for the services in dispute is $54,600.09. This amount less the amount previously paid by the insurance carrier of $53,731.65 leaves an amount due to the requestor of $868.44. 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 $868.44.

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 $868.44 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		April 26, 2021
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.