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
Crescent Medical Center

Respondent Name
Continental Casualty Co

MFDR Tracking Number
M4-21-1718-01

Carrier's Austin Representative
Box Number 57

MFDR Date Received
May 28, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The expected allowed amount was $83,484.32 per the workers comp fee schedule."

Amount in Dispute: $83,484.32

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Essentially, Foresight's review indicates that the healthcare provider did not submit an invoice showing cost minus any discounts or rebated received for the items per regulation or "net invoice cost". …It is therefore impossible to tell the true cost of the implants to the provider with the documents submitted."

Response Submitted by: Brian J Judis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 2 – 7, 2021	Inpatient Hospital Services	$83,484.32	$16,953.24

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

- 4458 – Foresight – charges for surgical implants are reviewed separately by Foresight Medical
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Is the insurance carriers' position 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?
4. What is the additional recommended payment for the implantable items in dispute?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent states, "the healthcare provider did not submit an invoice showing cost minus any discounts or rebated received for the items per regulation or "net invoice cost". The requirements of rule §134.404 (g) (1) states in pertinent part, A facility billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. Review of the submitted "Invoice" 02037 includes the required certification statement. The respondents' position is not supported. The services in dispute will be reviewed per applicable fee guidelines.
2. 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.

   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.

   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).

Billed charges	Implant charge	Facility's billed charges less implants billed charge	Total DRG payment	Multiplied by 108%
$233,220.46	$183,625.00	$49,595.46	$48,043.50	$51,886.98

3. 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 459. The services were provided in Lancaster, Texas. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $48,043.50. This amount multiplied by 108% results in a MAR of $51,886.98.
4. Additionally, the provider requested separate reimbursement of implantables. Per §134.404(g): Implantables, 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 include:

Item name claim	Item name from invoice	Billed Price	Cost/Unit	# Units	Total Cost	10%	Total Allowed Per Implantable
Screw 6.5x45mm	Tiger Spine 5500	$36,000.00	$3,600.00	2	$7,200.00	$720.00	$7,920.00
Screw 6.5x50mm	Tiger Spine 5500	$36,000.00	$3,600.00	2	$7,200.00	$720.00	$7,920.00
Caps Set	Set Screw	$9,500.00	$475.00	4	$1,900.00	$190.00	$2,090.00
Cage 7mm.25mm	Lumbar Cage	$34,000.00	$6,800.00	1	$6,800.00	$680.00	$7,480.00
Cage 10mmx25mm	Lumbar Cage	$34,000.00	$6,800.00	1	$6,800.00	$680.00	$7,480.00
Chips 30cc Bone1-4mm	Cancellous Crush	$34,125.00	$2,275.00	3	$6,825.00	$682.50	$7,507.50

The total net invoice amount (exclusive of rebates and discounts) is $183,625.00. 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 $38,725.00.

5. The total recommended payment for the services in dispute is $90,611.98. This amount less the amount previously paid by the insurance carrier of $73,658.74 leaves an amount due to the requestor of $16,953.24. 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 $16,953.24.

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 $16,953.24 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		June 24, 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.