TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
North Central Surgical Hospital

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-21-2257-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
August 10, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 25, 2021	111-278	$18,399.24	$0.00
January 25, 2021	X9907	$3240.00	$0.00
	Total	$21,639.24	$0.00

Requestor's Position

The requestor did not submit a position statement but rather submitted a copy of their reconsideration that states, "In accordance to the worker compensation guidelines the invoice should be processed and paid per the IPPS Pricer Calculations for the DRG time 108%.

Amount in Dispute: $21,639.24

Respondent's Position

Texas Mutual has elected to reach out to the provider to negotiate payment of the disputed services in lieu of audit.

Response Submitted by: Texas Mutual

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code §134.404 sets out the acute care hospital fee guideline for inpatient services.

2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

Denial Reasons

The insurance carrier [reduced or denied] the payment for the disputed services with the following claim adjustment codes:

- P12 – Workers compensation jurisdictional fee schedule adjustment
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- 468 – Reimbursement is based on the medical hospital inpatient prospective payment system methodology
- 897 – Separate reimbursement for implantable made in accordance with DWC Rule Chapter 134; Subchapter (E) Health Facility fees
- 920 – Reimbursement is being allowed based upon a dispute.

Issues

1. Is the insurance carrier's reduction based on the fee schedule supported?

2. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards inpatient hospital facility services with a separate request for payment of implants 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).

2. Review of the submitted documentation finds that the DRG code assigned to the services in dispute is 454. The services were provided at North Central Surgical Center, Dallas, Texas. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $38,235.37. This amount multiplied by 108% results in a MAR of $41,294.20.

   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 the total net invoice amount (exclusive of rebates and discounts) is $22,213.80. 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 $2,000.00. The total recommended reimbursement amount for the implantable items is $24,213.80.

   The total recommended payment for the services in dispute is $65,508.00. The amount paid by the insurance carrier is $65,544.27. No additional payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 19, 2021 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC

§133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must 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*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.