



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Metdalspl LLC

**Respondent Name**

Travelers Indemnity Co of Connecticut

**MFDR Tracking Number**

M4-23-0952-01

**Carrier's Austin Representative**

Box Number 5

**DWC Date Received**

December 27, 2022

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 7, 2022	111-278	\$5,401.00	\$0.00
<b>Total</b>		\$5,401.00	\$0.00

### Requestor's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration that states, "According to TX workers compensation guidelines implants should be reimbursed at manual cost plus 10%, and the expected reimbursement is \$5,401.00. Please remit payment for remaining balance of \$770.00."

**Amount in Dispute:** \$770.00

### Respondent's Position

The Carrier has reviewed the documentation and determined the Provider is not entitled to additional reimbursement. The Carrier calculated reimbursement based on the invoices provided with the billing. The Carrier reimbursed the following implantables: 1 fixation pin (\$100), 2 titanium cervical cages (\$1,800), 1 aptitude anterior cervical plate (\$900); 2 aptitude 14 mm fixed screws \$(470); and 4 aptitude 16 mm fixed screws (\$940). The Carrier did not reimburse for the 14 mm drill bit as this was not an implantable device, so the total implantable cost is \$4,210.00. After adding the implantable mark-up of 10%, the Carrier has calculated the Maximum Allowable

Reimbursement to be \$4,631.00. As reimbursement for these services has previously been issued in the amount of \$4,631.00 on the Explanation of Reimbursement issued 06-24-2022, no further reimbursement is due for the disputed services.”

**Response Submitted by:** Travelers

## **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:

- 2005 – No additional reimbursement allowed after review of appeal/reconsideration
- P12 – Workers’ compensation jurisdictional fee schedule adjustment
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- W3 – Bill is a reconsideration or appeal

### Issues

1. What is the rule applicable to separate reimbursement of implants?
2. What fee guideline is applicable to reimbursement of inpatient hospital services?
3. Is requestor entitled to additional reimbursement?

### Findings

1. The requestor is seeking additional reimbursement of implants that were rendered during an inpatient hospital surgical procedure. The insurance carrier originally denied the claim for the implants due to lack of information but later made a payment.

The disputed charges will be reviewed per applicable fee guideline DWC Rule 28 TAC §134.404(f), that requires 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](http://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 implants was requested. 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 medical bill finds that the implants included under revenue code 278 have a billed amount of \$7,068. Review of the submitted itemized bill and operative report details the following implants.

- Screw fixed Self Tap TI 4.0x14 (2) for \$706.00 with a cost of \$234.00 each for a total cost of \$470.00.
- Screw Fixed Self Tap TI 4.0x16 (4) for \$1412.00 with a cost of \$2345.00 each for a total cost of \$940.00.
- DBM Fibers Plus 2.5CC (3) for \$900.00 with a cost of \$300.00 for a total cost of \$600.00.
- Plate Cerv TI 1 LWCWEL 33MM (1) for \$1350.00 with a cost of \$900.00 for a total cost of \$900.00
- Cage ACDF TI 16x13x8 7" (2) for \$2700.00 with a total cost of \$900.00 each for a total cost of \$1800.00.

The total net invoice amount (exclusive of rebates and discounts) is \$4,710.00. 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 \$471.00. The total recommended reimbursement amount for the implantable items is \$5,181.00.

The maximum allowable reimbursement (MAR) is calculated according to §134.404(f)(1)(B)(2) which states in pertinent part, a facility or surgical implant 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. 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 subsection (g) of this section.

Billed charges	Implant charge (deducted from billed charges)	Amount entered into PPS Pricer	Total DRG payment	Multiplied by 108%
\$53,948.75	\$7,068.00	\$46,880.75	\$20,061.67	\$21,666.60

- 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 029. The services were provided at Addison, Texas.

Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is \$20,061.67.

This amount multiplied by 108% results in a MAR of \$21,666.60 plus an additional \$5,181.00 for the implants for a total of \$26,847.60.

- The total recommended payment for the services in dispute is \$26,847.60. This amount less the amount previously paid by the insurance carrier of \$31,225.67 leaves an amount due to the requestor of \$0.00. 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 requestor 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

February 1, 2023  
\_\_\_\_\_  
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](http://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](mailto: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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).