TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
PROVIDENCE MEMORIAL HOSPITAL

Respondent Name
BANKERS STANDARD INS CO

MFDR Tracking Number
M4-23-1373-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
February 13, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 15, 2022 to February 18, 2022	Inpatient Hospital Service	$17,085.49	$0.00
	Total	$17,085.49	$0.00

Requestor's Position

"The Hospital's records reflect the patient was injured in a work-related injury. The Hospital billed Broadspire, but the claim was underpaid. The Hospital is entitled to proper reimbursement because it provided the medically necessary procedure for treatment directly related to patient's work-related injury."

Amount in Dispute: $17,085.49

Respondent's Position

"ESIS Med Bill Impact's Bill Review Department reviewed the above mentioned date of service and found that the provider was not due additional money. It has been determined that ESIS Med Bill Impact will stand on the original recommendation of $53,892.13.

Response Submitted by: ESIS

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 denied the payment for the disputed services with the following claim adjustment codes:

- P12 – Workers Compensation Jurisdictional fee schedule adjustment
- A31 – Services reviewed by nurse
- 468 – Reimbursement is based on the medical hospital inpatient prospective payment system methodology
- P13 – Payment reduced or denied based on workers compensation jurisdictional & regulations or payment policies, use only if no other code is applicable
- B85 – Review of this code has resulted in an adjusted reimbursement
- 790 – This charge was reimbursed in accordance to the Texas medical fee guideline
- 252 – An attachment other documentation is required to adjudicate this claim/service
- 253 – In order to review this charge please submit a copy of the invoice
- 350 – Bill has been identified as a request for reconsideration or appeal
- 885 – Review of this code has resulted in a adjudicated reimbursement
- D00 – Based on further review, no additional allowance is warranted
- W3 - In accordance with TDI/DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

Issues

1. Is PROVIDENCE MEMORIAL HOSPITAL entitled to additional reimbursement?

Findings

1. The requestor in dispute is seeking additional reimbursement for February 15, 2022 to February 18, 2022 dates of service.

   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.

   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 implantables include:

   "SP LUM LAT OTHER" as identified in the itemized statement and labeled on the invoice as "K Wire C Lateral" with a cost per unit of $40.00; "SP ROD STANDARD" as identified in the itemized statement and labeled on the invoice as "PI5.5 TI 510mm alloy rod " with a cost per unit of $175.00; "EN GRANUELS 30CC" as identified in the itemized statement and labeled on the invoice as "CANCELLOUS CRUSHED 30CC" with a cost per unit of $413.00 at 2 units, for a total cost of $826.00.

   Review of the submitted documentation found insufficient evidence to support the cost of the items identified as implants for SP BN EXTN ALGF, BN GRNAUELS 30CC, SP SET S/B/C/N, SP BN EXTN ALGF, SP LUM DEV PLIF and SP PED SCRW ST. No reimbursement due.

   Per §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 §134.404(g). The facility's total billed charges for the separately reimbursed implantable items are $341,427.16. Accordingly, the facility's total billed charges shall be reduced by this amount for the purpose of calculating any outlier payments.

   The total net invoice amount (exclusive of rebates and discounts) is $1,001.00. 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 $100.10. The total recommended reimbursement amount for the implantable items is $1,101.10.

   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 460. The services were provided

at El Paso, TX. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $40,971.49. This amount multiplied by 108% results in a MAR of $45,350.31.

The total allowable reimbursement for the services in dispute is $45,350.31. This amount less the amount previously paid by the insurance carrier of $53,592.23 leaves an amount due to the requestor of $0.00. No additional reimbursement can be 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 of $0.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

[redacted]		March 31, 2023
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 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.