



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

Baylor Surgical Hospital

Respondent Name

XL Specialty Insurance Co

MFDR Tracking Number

M4-17-1525-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

January 23, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Total allowable per Medicare \$6,934.27. A reconsideration was submitted to the carrier with no response."

Amount in Dispute: \$452.75

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of an acknowledgement of receipt of the medical fee dispute resolution on January 31, 2017. Texas Administrative Code §133.307 (d) (1) states,

Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.

- (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

As no response was received, this dispute will be reviewed based on available information

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: March 14, 2016, C1713, C1762, \$452.75, \$450.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 §134.403 sets out the reimbursement guidelines for services provided in an outpatient setting.
3. The insurance carrier listed the following claim adjustment codes:
  - P1 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup
  - 97 – This code has a status Q APC indicator and is packaged into other APC does that have been identified by CMS
  - 25 – In order to review this charge we will need a copy of the invoice

## **Issues**

1. What is the applicable rule that pertains to reimbursement?
2. Is the requestor entitled to additional reimbursement?

## **Findings**

1. The requester seeks additional reimbursement for \$452.75 for separate implantable reimbursement for outpatient hospital services rendered March 14, 2016.

The insurance carrier made adjustment to the payment made as P1 – “This hospital outpatient allowance was calculated according to the APC rate, plus a markup” and 25 – “In order to review this charge we will need a copy of the invoice.”

28 Texas Administrative Code §134.403 (f) and (g) states in pertinent parts below,

The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

(f) (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 200 percent;

(B) 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 130 percent.

(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.

Therefore, the calculation of the implantables in dispute is as follows:

Procedure Code	Billed Amount	Invoice Amount	Plus 10 percent	Total allowable	Amount paid	Amount due
C1713	2.50	None found	n/a	n/a		
C1762	\$4,500.00	\$4,500.00	\$450.00	\$4,950.00	\$4,500.00	\$450.00

Review of the documents included within the dispute found no invoice to support the code in dispute C1713 - Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable).

Therefore the carrier's denial of this service as 25 – "In order to review this charge we will need a copy of the invoice" is supported.

3. The total recommended reimbursement for the disputed services is \$4,950.00. The insurance carrier has paid \$4,500.00 leaving an amount due to the requestor of \$450.00. 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 \$450.00.

**ORDER**

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$450.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order

**Authorized Signature**

_____	_____	April 7, 2017
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, 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.**