



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

Texas Orthopedic Hospital

Respondent Name

Liberty Mutual Insurance Co

MFDR Tracking Number

M4-17-2933-01

Carrier's Austin Representative

Box Number 1

MFDR Date Received

June 5, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim should have been paid in accordance with 28 T.A.C. §134.404, which states, "(1) the sum of the Medicare facility specific reimbursement amount and any applicable outlier amount shall be multiplied by (A) 108 per cent..." In addition to reimbursement that the Fee Schedule provides for Implants. This is the formula to be used absent certain circumstances that do not apply to the present case. Using this formula, the hospital would have been entitled to \$25,918.82 in reimbursement. The Carrier only paid \$20,430.88. Therefore, the Hospital contends an additional \$5,487.94 remains owed."

Amount in Dispute: \$5,487.94

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "A re-review has been performed on this bill for statement from-through 12/8/16-12/23/16. The bill was processed correctly based on provider's original submission. DRG 483 (MAJOR JOINT/LIMB REATTACHMENT PROCEDURE OF UPPER EXTREMITIES) was priced CMS' IPPS rate of \$14,287.33 @ 143%. The Provider did not request separate implant reimbursement on original review. A non-certified invoice has been noted, and is attached for review."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: December 8 - 23, 2016, Inpatient Hospital Services, \$5,487.94, \$0.00

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 §134.404 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:
 - Z710 - The charge for this procedure exceeds the fee schedule allowance
 - P300 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
 - U634 – Procedure code not separately payable under Medicare and or fee schedule guidelines
 - B13 – The charge for this procedure exceeds the fee schedule allowance
 - W3 – The charge for this procedure exceeds the fee sch
 - 193 – The charge for this procedure exceeds the fee schedule allowance

Issues

1. Did the requestor request implants in accordance with Division guidelines?
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. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking separate reimbursement for implantables that were provided as part of the outpatient hospital services in dispute. The hospital in this case argues that it should have been paid separately for the implantables.

According to 28 Texas Administrative Code §134.403(f)(1), the maximum allowable reimbursement (MAR) for outpatient hospital services such as those in dispute shall be (A) 200% of the Medicare allowable, **unless** (B) a facility **requests** separate reimbursement for implantables. 28 Texas Administrative Code §133.10 (f)(2)(QQ) furthermore **requires** that the hospital use a specific field on the UB-04 to make such a request for separate reimbursement:

(QQ) remarks (UB-04/field 80) is required when separate reimbursement for surgically implanted devices is requested.

Review of the submitted medical bills finds that neither the original billing, nor the bills submitted for reconsideration contain the required data in field 80. For that reason, the Division finds that the carrier in this case correctly deferred to the higher 143% rate outlined in §134.403(f)(1)(A) as noted in their position statement. Therefore, the calculation of the maximum allowable reimbursement is discussed below.

2. This dispute regards the facility medical services of an inpatient acute care hospital with reimbursement subject to the provisions of Code 28 Texas Administrative Code §134.404(f), which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule.

Per §134.404(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 143 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested; for that reason, the MAR is calculated according to §134.404(f)(1)(A).

3. Per §134.404(f)(1)(A), the sum of the Medicare facility specific amount, including any outlier payment, is multiplied by 143%. 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 483. The services were provided at Texas Orthopedic Hospital. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is \$14,287.31. This amount multiplied by 143% results in a MAR of \$20,430.85.

4. The total recommended payment for the services in dispute is \$20,430.85. The insurance carrier has paid \$20,430.88. The amount due to the requestor is \$0.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

_____	_____	June 16, 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 Rule §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. **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.