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
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-24-1481-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
March 11, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 16, 2023	111-278	$1,141.80	$949.31
	Total	$1,141.80	$949.31

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of a document titled "Reconsideration" dated January 31, 2024 that states, "Per EOB received, Rev code 278/Implants were not paid correctly per TX work comp guidelines. The expected reimbursement for Rev code 278/Implants is $10,634.80. Per TX Rule 134.402, implants should be reimbursed at manual cost plus 10% ($2,000 max). Previous payment received for implants $9,493.00."

Amount in Dispute: $1,141.80

Respondent's Position

"...the provider billed at the invoice cost of the implants. It is unreasonable for the provider to expect to be paid more than what was charged for these items. If the provider wants to be paid at cost + 10%, then their charges need to reflect that amount. We are not liable for a billing error on the provider and should not be expected to pay more than what was charged."

Response Submitted by: Foresight

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 (TAC) §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:

- 1 – This procedure on this date was previously reviewed.
- 2 – Reduction is based on the Inpatient Fee Schedule.
- 3 - 131 – Claim specific negotiated discount.
- 4 - 18 – Duplicate claim/service.
- 5 – P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 10 – Upon review of submitted request for reconsideration, ForeSight has determined that no additional allowance will be made.
- 14. This item was determined to not have been permanently implanted during the procedure.
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.

Issues

1. Is the respondent's position supported?

2. What rule is applicable to reimbursement?

3. Is requestor entitled to additional reimbursement?

Findings

1. The requestor states in their position statement, "It is unreasonable for the provider to expect to be paid more than what was charged for these items. If the provider wants to be paid at cost + 10%, then their charges need to reflect that amount. We are not liable for a billing error on the provider and should not be expected to pay more than what was charged." DWC Rule 134.404 (e)(2) states in pertinent part, "Except as provided in subsection (h) of this section, **regardless of billed amount**, reimbursement shall be: if no contracted fee schedule exists that complies with Labor Code §413.011,

the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."

2. This dispute regards inpatient hospital facility services with payment subject to DWC Rule 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).

   Per §134.404(f)(1)(B), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment by 108%.

   Review of the submitted documentation finds that the DRG code assigned to the services in dispute is 472. The services were provided at North Central Surgical Center in Dallas, Texas. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $20,444.20. This amount multiplied by 108% results in a MAR of $22,079.74.

   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:

   - Screw Infinity Multi Axi" as identified in the itemized statement with a cost per unit of $700.00 at 2 units, for a total cost of $1,400.00;
   - "Rod Infinity Pre-cut 3.5" as identified in the itemized statement with a cost per unit of $175.00 at 2 units, for a total cost of $350.00;
   - "Screw Infinity Multi Axi" as identified in the itemized statement with a cost per unit of $700.00 at 8 units, for a total cost of $5,600.00;
   - "Set Screw 3600215 M6" as identified in the itemized statement with a cost per unit of $65.00 at 10 units, for a total cost of $650.00;
   - "Rod Infinity Pre-cut 3.5" as identified in the itemized statement. However, review of the submitted "Patient Implant Location" found this item marked as "IN&OUT".
   - "Putty Magnet easypack" as identified in the itemized statement with a cost per unit of $1,147.00;
   - "Graft cancellous chips" as identified in the itemized statement with a cost per unit of

$346.00.

The total net invoice amount (exclusive of rebates and discounts) is $9,493.00. 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 $949.30. The total recommended reimbursement amount for the implantable items is $10,442.30.

3. The total recommended payment for the services in dispute is $32,522.04. This amount less the amount previously paid by the insurance carrier of $31,572.73 leaves an amount due to the requestor of $949.31. This amount 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 established that additional reimbursement of $949.31 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 additional reimbursement for the disputed services. It is ordered that Indemnity Insurance Co of North America must remit to North Central Surgical Hospital $949.31 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 3, 2024 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.