Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ECTOR COUNTY HOSPITAL
3255 WEST PIONEER PARKWAY
ARLINGTON TX 76013

Respondent Name
LIBERTY INSURANCE CORP

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-11-3415-01

MFDR Date Received
JUNE 8, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary per the Request for Reconsideration Letter dated May 4, 2011: "HRA has been hired by ECTOR COUNTY HOSPITAL DISTRICT to audit their workers compensation claims. Per your Explanation of Review, network reductions based on the FIRST HEALTH contract have been taken, and payment of $107,777.30 has been made. In our audit of this claim, we used the TDI DWC rules. Per those rules, inpatient services are to be reimbursed at 143% of the Medicare allowable. For this DRG and this location, the CMS pricer program shows a reimbursement of $99,405.55. 143% of this amount is $142,149.94. Furthermore, you have taken a 'carve out' for the implants and the calculation of this carve out was not in compliance with TDI DWC rules. TDI DWC rules state that the carrier is to pay cost plus 10% (not to exceed $2,000 per surgery). Also according to TDI DWC rules, separate payment for implants is at the discretion of the facility. Since the facility did not request a carve out, this should not have been done."

Amount in Dispute: $20,157.65

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have received the medical dispute filed by Ector County Hospital for services rendered…The bill and documentation attached to the medical dispute have been re-reviewed and our position remains unchanged. Our rationale is as follows: The provider submitted implant invoices with the TWCC required attestation statement upon initial submission of the bill. The documentation included implant invoices individually certified and signed by Connie Sullenger. Because the provider submitted certified invoices upon initial bill submission, Liberty Mutual processed this bill at the applicable rate of 108% of the DRG with the implants paid at cost + 10% as required. Certified implant invoices submitted with the original billing, we believe, demonstrates the provider's desire to have implants reimbursed separately. Liberty Mutual believes that Foundation Ector County Hospital has been appropriately reimbursed for services rendered…"

Response Submitted by: Liberty Mutual Insurance Group, 2875 Browns Bridge Rd, Gainesville GA 30504

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 19, 2010 Through July 14, 2010	Inpatient Hospital Surgical Services	$20,157.65	$20,157.65

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 24, 2010
   - 45 — (Z547) THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR FEE FOR SERVICE CONTRACT WITH FIRST HEALTH. FOR QUESTIONS REGARDING THIS ANALYSIS PLEASE CALL (800) 937-6824. THIS REIMBURSEMENT MAY REFLECT PAYMENT AT RATES LESS THAN YOUR DISCOUNTED CONTRACT RATE IN ACCORDANCE WITH YOUR PPO NETWORK CONTRACT AND OUR ACCESS AGREEMENT WITH THEM. (Z547)
   - 42 — (Z710) THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE. (Z710)
   - 42 — (PA) FIRST HEALTH
   - 24 — (P303) THIS SERVICE WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT. (P303)

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Which reimbursement calculation applies to the services in dispute?
3. Did the facility or a surgical implant provider request separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g)?
4. What is the maximum allowable reimbursement for the services in dispute?
5. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:

   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or

   (2) 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."

   No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under §134.404(f).

2. §134.404(f) states that "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 Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   (A) 143 percent; unless
   (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 108 percent."

   No documentation was found to support that the facility requested separate reimbursement for implantables; for that reason the MAR is calculated according to §134.404(f)(1)(A).

3. Review of the submitted documentation finds that separate reimbursement for implantables was not requested in accordance with 28 Texas Administrative Code §134.404(g). Although the requestor submitted bill with certified implant invoices to the insurance carrier, the requestor did not formally request, in writing, separate reimbursement for the implantables.

4. 28 Texas Administrative Code §134.404(f)(1)(A) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Documentation found supports that the DRG assigned to the services in dispute is DRG 957, and that the services were provided at Ector County Hospital. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $99,405.55. This amount multiplied by 143% results in a MAR of $142,149.94.
5. The division concludes that the total allowable reimbursement for the services in dispute is $142,149.94. The respondent issued payment in the amount of $107,777.30. Based upon the documentation submitted, and the requestors *Table of Disputed Services*, additional reimbursement in the amount of $20,157.65 is recommended

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $20,157.65 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		October 22, 2012
Signature	Medical Fee Dispute Resolution Officer	Date
		October 22, 2012
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.