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

INNOVA HOSPITAL SAN ANTONIO
2201 TIMBERLOCH PLACE STE 200
THE WOODLANDS TX 77380

Respondent Name
Liberty Insurance Corp

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-14-1575-01

MFDR Date Received
February 3, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…We have received a total of $43,405.35 from Liberty Mutual in reimbursement. According to the fee schedule, we are entitled to at least $17,965.46 more in reimbursement."

Amount in Dispute: $17,965.46

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Liberty Mutual believes that Innova Hospital San Antonio has been appropriately reimbursed for services rendered…"

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 19 – 20, 2013	Inpatient Hospital Surgical Services	$17,965.46	$17,965.46

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:
   - Z710 – The charge for this procedure exceeds the fee schedule allowance
   - 193 – Original payment decision is being maintained
   - X212 – This procedure is included in another procedure performed on this date

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. What is the maximum allowable reimbursement for the services in dispute?
4. 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."

   Review of the documentation finds that that the facility requested separate reimbursement for implantables on the original claim submission. At reconsideration a statement was made that "Since we DID NOT, nor are we, asking for separate implant reimbursement, we are requesting payment at 143% of the Medicare DRG." This statement is contrary to original claim submission; for that reason, the requirements of subsection (g) apply.

3. §134.404(g) states, in pertinent part, that "(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.
   (1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

Review of the documentation found supports that the following items were certified as required by (g):

Itemized Statement Rev Code or Charge Code	Itemized Statement Description	Cost Invoice Description	# Units & Cost Per Unit	Cost Invoice Amount	***Per item*** Add-on (cost +10% or $1,000 whichever is less).
C1762	Surgiflo Hemostatic Matrix	Surgiflo Matrix	N/A	N/A	Item does not meet the definition of implantable
C1778	Lead Kit statement	Lead	1 @ 26,040.00	$ 8,510.00	$ 9,361.00
C1820	Restore Sensor	INS 37714 Sensor	1 @ $83,800.00	$20,950.00	$21,950.00
C1787	Patient Programmer	Programmer S7746 SCS Patient	1 @ 4,760.00	$ 1,190.00	$ 1,309.00

Total Supported Cost	**Sum of Per-Item Add-on**
$30,650.00	$32,620.00

The division finds that the facility supported separate reimbursement for these implantables, and that the cost invoices were certified as required. Therefore, the MAR is calculated according to §134.404(f)(1)(B).

4. §134.404(f)(1)(B) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 108%, ***plus*** reimbursement for items appropriately certified under §134.404(g). The Medicare IPPS payment rates are found at http://www.cms.gov, and the sum of the per-item add-on for which separate reimbursement was requested are taken from the table above.

   - Documentation found supports that the DRG assigned to the services in dispute is 490, and that the services were provided at INNOVA HOSPITAL SAN ANTONIO. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $42,916.65. This amount multiplied by 108% results in an allowable of $46,349.98.
   - The total net invoice amount (exclusive of rebates and discounts) is $30,650.00. 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 $1,970.00. The total recommended reimbursement amount for the implantable items is $32,620.00.

   The total allowable reimbursement for the services in dispute is $78,969.98. The amount previously paid by the insurance carrier is $43,817.10. The requestor is seeking additional reimbursement in the amount of $17,965.46. This amount 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 $17,965.46 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 26, 2014 Date
Signature	Medical Fee Dispute Resolution Manager	March 26, 2014 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, 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 MDR 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.