SOAH DOCKET NO. 454-14-2265.M4-NP
MR NO.

HOUSTON NORTHWEST MEDICAL CENTER, **Petitioner**	§	**BEFORE THE STATE OFFICE**
v.	§	**OF**
ACE AMERICAN INSURANCE COMPANY, **Respondent**	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Houston Northwest Medical Center (Provider or HNMC) challenges the Medical Fee Dispute Findings and Decision of the Texas Department of Insurance, Division of Worker's Compensation (Division or DWC), that declined to order Ace American Insurance Company (Carrier), the workers' compensation carrier, to reimburse Provider an additional $2,885.45 for medical services provided by HNMC to an injured worker (Claimant). The Administrative Law Judge (ALJ) concludes that Provider met its burden of proving that it should be reimbursed the additional $2,885.45.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

There are no disputed issues regarding jurisdiction or the adequacy of notice. Therefore, those matters are set out in the Findings of Fact and Conclusions of Law without further discussion here.

Provider filed a request for medical fee dispute resolution with the Division on October 23, 2013. On December 5, 2013, the Division issued its Medical Fee Dispute Resolution Findings and Decision (Findings and Decision). Provider filed a timely request for a hearing at the State Office of Administrative Hearings (SOAH) to contest the Division's

determination. The hearing was held May 7, 2014, before ALJ Henry D. Card, at SOAH's offices in Austin, Texas. Provider was represented by P. Matthew O'Neil. Carrier was represented by John Fundis. The record closed on May 7, 2014.

II. APPLICABLE LAW

The Division's Hospital Facility Fee Guideline—Outpatient (the Guideline) is set out at 28 Texas Administrative Code (TAC) § 134.403. This dispute concerns the application of 28 TAC § 134.403(f) and (g). Those subsections state:

> (f) The reimbursement calculation used for establishing the MAR[1] 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.
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> (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
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> (A) 200 percent; unless
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> (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.
>
> (2) When calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed

[1] "MAR" is the acronym for "maximum allowable reimbursement."

charges for any item reimbursed separately under subsection (g) of this section.

(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.

In other words, outpatient services are to be reimbursed at 200 percent of the Medicare facility-specific amount, unless the facility bills the carrier separately for implantables. In that case, the reimbursement is 130 percent of the Medicare facility-specific amount, plus the cost of the implantables plus 10 percent of that cost.

The issue in this case is whether Provider requested separate reimbursement for implantables. Provider claims that it did. Carrier claims that Provider did not and that Carrier correctly reimbursed Provider a lower amount, based on 200 percent of the Medicare facility-specific amount.

III. EVIDENCE AND ANALYSIS

A. Evidence

The facts of this case are uncontested. On November 29, 2012, Claimant underwent outpatient surgery at Provider's facility. The surgery required the use of implantables. Provider filed a claim for reimbursement with Carrier that included copies of the invoices for the cost of the implantables. Provider did not include a cover letter or a comment on the claim form (Form UB-04) stating that it was requesting separate reimbursement for the implantables. Claimant therefore reimbursed Provider at 200 percent of the Medicare facility-specific amount. The Division agreed with Carrier that it had reimbursed correctly.

Provider argued that submission of the invoices constituted a request for separate reimbursement. Provider observed that if it were not requesting separate reimbursement, there would be no point in including the invoices for the implantables. Provider argued that the language of the Guideline does not require a separate statement.

Ron Vaughan, Corporate Director of Payer Compliance for Tenet Healthcare Corporation (Tenet),[2] testified that the bills in this case were typical, Tenet has never included a specific statement that it was billing separately for implantables, and to his knowledge, Tenet's method has never been challenged in the manner it was being challenged by Carrier in this case. He estimated that Tenet has submitted 50,000 or more bills to carriers.

On cross-examination, Mr. Vaughan agreed that the Medicare facility-specific reimbursement amount calculated by the Division was a few dollars less than the one requested by Provider. He did not have any explanation for that discrepancy. He also agreed that the implantables invoices added up to $6,304.34, which is several hundred dollars higher than the $5,708.57 figure calculated by Provider in its request. Mr. Vaughan was not sure of the reason for that discrepancy, either, although he stated it was possible that some of the items in the invoices had been used for other surgeries or had been ordered for this surgery but not actually used.

Carrier presented evidence that at least some other providers typically included a specific request for separate reimbursement of implantables in their bills, particularly in Box 80, which is the "remarks" section of the UB-04.[3] Carrier argued that the discrepancies between the actual invoices and the request in this instance illustrated the need for providers to specify whether they were requesting separate reimbursement.

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[2] HNMC is owned by Tenet.

[3] Carrier Ex. C.

Carrier also argued that the Division's Decision and Findings in this case, as well as its comments on the Guideline when it was adopted in 2008, indicated that the Division expected providers to indicate specifically which reimbursement methodology they were seeking. The commentary states:

> The Division agrees that identifying reimbursement methodologies is important to the successful implementation of the adopted rules. The Division is currently investigating the use of field 80 on UB-04 and the use of the billing notes in the ANSI X12 837i transaction set. Specific guidance regarding this process will be available through the Division's outreach and implementation efforts subsequent to the adopted rules.[4]

B. Analysis

The ALJ agrees with Provider that the Guideline does not require providers to file a statement specifying which type of reimbursement they are seeking. Mr. Vaughan provided convincing, unrebutted testimony that Provider has been using this method, without challenge, for years. The commentary cited by Carrier does not require providers to use Box 80 to identify the reimbursement methodology being requested, and there was nothing in the record to suggest that the Division subsequently has required the use of Box 80 or of any other specific method.

Although Provider's invoices for implantables totaled more than its request, that discrepancy did not render Provider's billing methodology inappropriate. As Provider pointed out, Carrier was entitled under the rule to audit the bills submitted.

The ALJ finds that Provider billed Carrier separately for implantables and concludes that Provider's billing method complied with 28 TAC § 134.403(f)(1)(B) and (g). Although Provider may have over-calculated the Medicare facility-specific payment amount by a few dollars, its

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[4] 33 Tex. Reg. 420 (Jan. 11, 2008) (Carrier Ex. D at 24).

calculated implantables cost was several hundred dollars below the cost shown on the invoices. Provider's calculations showed that Carrier owed it an additional $2,885.45 for the services in question. The ALJ concludes Carrier should reimburse Provider that additional amount, plus interest as required.

IV. FINDINGS OF FACT

1. Houston Northwest Medical Center (Provider) filed a request for medical fee dispute resolution with the Texas Department of Insurance, Division of Workers' Compensation (Division or DWC) on October 23, 2013.

2. On December 5, 2013, the Division issued its Medical Fee Dispute Resolution Findings and Decision (Findings and Decision).

3. Provider filed a timely request for a hearing at the State Office of Administrative Hearings (SOAH) to contest the Division's determination.

4. The hearing was held May 7, 2014, before Administrative Law Judge Henry D. Card, at SOAH's offices located in Austin, Texas. Provider was represented by P. Matthew O'Neil. Carrier was represented by John Fundis. The record closed on May 7, 2014.

5. On November 29, 2012, an injured worker (Claimant) underwent outpatient surgery at Provider's facility that required the use of implantables.

6. Provider filed a claim for reimbursement with Ace American Insurance Company (Carrier) that included copies of the invoices for the cost of the implantables.

7. Provider did not include a cover letter or a comment on the UB-04 stating that it was requesting separate reimbursement for the implantables.

8. Claimant reimbursed Provider at 200 percent of the Medicare facility-specific amount.

9. In its Finding and Decision, the Division agreed with Carrier that it had reimbursed correctly.

10. Provider's billing was its usual method of requesting separate reimbursement of implantables.

11. Tenet, which owns Provider, does not typically include a specific statement that it is billing separately for implantables.

12. Submission of the invoices constituted a request for separate reimbursement of the implantables.

13. Although Provider may have over-calculated the Medicare facility-specific payment amount by a few dollars, its calculated implantables cost was several hundred dollars below the cost shown on the invoices.

14. Carrier owes Provider an additional $2,885.45 for the services in question.

V. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order. Tex. Lab. Code ch. 413 and Tex. Gov't Code ch. 2003.

2. Adequate and timely notice of the hearing was provided. Tex. Gov't Code §§ 2001.051 and 2001.052.

3. Provider had the burden of proof in this proceeding by a preponderance of the evidence.

4. The Division's Hospital Facility Fee Guideline—Outpatient (the Guideline) is set out at 28 Texas Administrative Code (TAC) § 134.403.

5. The Guideline does not require providers to file a statement specifying which type of reimbursement they are seeking.

6. The commentary cited by Carrier does not require providers to use Box 80 on the claim form to identify the reimbursement methodology being requested.

7. Provider billed Carrier separately for implantables in compliance with 28 TAC § 134.403(f)(1)(B) and (g).

8. Carrier should reimburse Provider an additional $2,885.45, plus interest as required.

ORDER

Carrier shall reimburse Provider an additional $2,885.45, plus interest as required.

NONPREVAILING PARTY DETERMINATION

Texas Labor Code § 413.0312(g) and 28 Texas Administrative Code § 133.307(h) require the nonprevailing party to reimburse DWC for the cost of services provided by SOAH. Texas Labor Code § 413.0312(i) requires SOAH to identify the nonprevailing party and any costs for services provide by SOAH in its final decision. For purposes of Texas Labor Code § 413.0312, Ace American Insurance Company is the nonprevailing party. The costs associated with this decision are set forth in Attachment A to this Decision and Order and are incorporated herein for all purposes.

SIGNED July 3, 2014.

HENRY D. CARD
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS