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
BAYLOR SURGICAL HOSPITAL

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-16-3074-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
June 9, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim listed above was not processed according to Texas fee guidelines for outpatient services. . . . We are requesting 130% of the Medicare allowable with implant cost."

Amount in Dispute: $4,613.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Ovation 1ml billed by the requestor with code C1763 does not meet the definition of an implant at Rule 134.403(b)(2)."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
January 7, 2016	Outpatient hospital services including implantable item(s) billed under procedure code C1763	$4,613.66	$971.49

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 §134.403 sets out the hospital facility fee guideline for outpatient services.
3. Texas Insurance Code §1305.006 establishes insurance carrier liability for out-of-network health care.
4. Texas Insurance Code §1305.153 sets out requirements for payment of network and non-network providers.
5. Texas Insurance Code §4201.002 defines words and terms related to utilization review.
6. This dispute involves authorized out-of-network services approved by the network in accordance with Insurance Code §1305.006. Insurance Code §1305.153(c) requires that out-of-network providers who render care as described by Insurance Code §1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation Accordingly, this request for additional reimbursement is reviewed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation.

7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION.
   - 55 – PROCEDURE/TREATMENT IS DEEMED EXPERIMENTAL/INVESTIGATIONAL BY THE PAYER.
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - 198 – PRECERTIFICATION/AUTHORIZATION EXCEEDED.
   - 217 – THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE.
   - 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
   - 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 356 – THIS OUTPATIENT ALLOWANCE WAS BASED ON THE MEDICARE'S METHODOLOGY (PART B) PLUS THE TEXAS MARKUP.
   - 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
   - 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824
   - 725 – APPROVED NON NETWORK PROVIDER FOR TEXAS STAR NETWORK CLAIMANT PER RULE 1305.153(C).
   - 759 – SERVICE NOT INCLUDED IN AND/OR EXCEEDS PREAUTHORIZATION APPROVAL
   - 761 – SERVICE CONSIDERED EXPERIMENTAL AND/OR INVESTIGATIONAL THEREFORE PREAUTHORIZATION IS REQUIRED.
   - 768 – REIMBURSED PER O/P FG AT 130% SEPARATE REIMBURSEMENT FOR IMPLANTABLES (INCLUDIGING CERTIFICATION) WAS REQUESTED PER RULE 134.403(G)
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. Is the item billed under procedure code C1763 experimental or investigational?
2. Are the insurance carrier's reasons for denial of payment supported?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The carrier denied payment for an item billed under code C1763 with claim adjustment reason codes:
   - 55 – PROCEDURE/TREATMENT IS DEEMED EXPERIMENTAL/INVESTIGATIONAL BY THE PAYER.
   - 761 – SERVICE CONSIDERED EXPERIMENTAL AND/OR INVESTIGATIONAL THEREFORE PREAUTHORIZATION IS REQUIRED.

   The determination of a service's experimental or investigational nature is assessed on a **case by case basis** through the process of utilization review (UR) pursuant to Texas Insurance Code §4201.002. We find no evidence the carrier performed utilization review as required by Texas Insurance Code §4201.002. Accordingly, the carrier's denials relating to the item's "experimental/investigational" nature are not supported.

2. The carrier denied payment for an implant item billed under code C1763 with claim adjustment reason codes:
   - 16 – CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION.
   - 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.

   The respondent's position statement asserts, "Ovation 1ml billed by the requestor with code C1763 does not meet the definition of an implant at Rule 134.403(b)(2)."

   Rule §134.404(b)(2), defines "implantable" as an object or device that is surgically: (A) implanted, (B) embedded, (C) inserted, (D) or otherwise applied …

Procedure code C1763 represents "connective tissue, nonhuman (includes synthetic)." Review of the submitted records finds insufficient information to support the disputed item meets the definition of procedure code C1763.

The itemized statement describes this item as "GRAFT TISSUE LG STEM CEL"; the invoice describes the item as "OVATION 1ML." The submitted master implant tracker describes the item as "MICRO-SPIN GRAFT TISSUE LG STEM CELL CELLULAR REPAIR MATRIX OVATION." The operative report states that "Ovation stem cell was injected into the area of the repair…"

Review of the submitted information finds insufficient information to describe the item injected into the injured employee or to support that the item meets the definition of an implantable. Based on the submitted records, the item is measured in milliliters (ml), and the operative report notes the item was "injected," supporting that the item is a liquid biological substance, not an object or device, and thus fails to meet the definition of an implantable in accordance with Rule §134.404(b)(2).

Review of the submitted documentation finds insufficient information to support the item as billed. The insurance carrier's denial reason is supported. Reimbursement for procedure code C1763 is not recommended.

3. This dispute regards outpatient facility services subject to DWC's *Hospital Facility Fee Guideline*, Rule §134.403, requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount applying Medicare Outpatient Prospective Payment System (OPPS) formulas and factors published in the Federal Register modified by DWC rules. Rule §134.403(f)(1) requires the Medicare facility specific amount and any outlier payment be multiplied by 200% unless separate payment for implants is requested in accordance with Rule §134.403(g).

   Although separate payment for implants was requested, as no qualifying implants were found eligible and no such items were separately paid in accordance with Rule §134.403(g), reimbursement for the services is calculated in accordance with Rule §134.403(f)(1), which requires the Medicare specific facility amount be multiplied by 200%.

   Medicare assigns an Ambulatory Payment Classification (APC) to OPPS services based on billed procedure codes and supporting documentation. The APC determines the payment rate. Reimbursement for ancillary items and services is packaged with the APC payment. CMS publishes quarterly APC rate updates, available at www.cms.gov.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure code 26952 is assigned APC 5121. The OPPS Addendum A rate is $1,455.26, which is is multiplied by 60% for an unadjusted labor-related amount of $873.16, in turn multiplied by the facility wage index of 0.9572 for an adjusted labor amount of $835.79. The non-labor related portion is 40% of the APC rate, or $582.10. The cost of services does not exceed the threshold for outlier payment. The sum of the labor and non-labor portions is $1,417.89. The Medicare facility specific amount of $1,417.89 is multiplied by 200% for a MAR of $2,835.78.

   The total recommended reimbursement for the disputed services is $2,835.78. The insurance carrier paid $1,864.29. The amount due to the requestor is $971.49. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division emphasizes that the findings in this decision are based on the evidence presented by the requestor and respondent available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $971.49.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $971.49, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	February 15, 2019
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.

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 form's instructions. The division must receive the request within twenty days of your receipt of this decision. The request may be faxed, mailed or personally delivered either to the division, using the contact information listed on the form, or to the field office handling the claim.

The party seeking review must deliver a copy of the request to all parties involved in the dispute at the same time the request is filed. Include a copy of this *Medical Fee Dispute Resolution Findings and Decision* together with any other information required by 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.