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 MEDICAL CENTER AT TROPHY CLUB

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-17-1956-01

Carrier's Austin Representative
Box Number54

MFDR Date Received
February 24, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are requesting 130% of the Medicare allowable with implant reimbursement."

Amount in Dispute: $8,250.01

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The HCPCS definition of C1765 is adhesion barrier…. Neither the definition of C1765 nor the manner in which it was used operatively … supports the billing of it as an implant."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
April 27, 2016	Outpatient Hospital Services – 64721, 24342, C1713, C1765	$8,250.01	$8,250.01

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. 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.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 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.
- 236 – THIS BILLING CODE IS NOT COMPATIBLE WITH ANOTHER BILLING CODE PROVIDED ON THE SAME DAY ACCORDING TO NCCI OR WORKERS COMPENSATION STATE REGULATIONS /FEE SCHEDULE REQUIREMENTS.
- 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.
- 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
- 435 – PER NCCI EDITS, THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF THE COMPREHENSIVE PROCEDURE.
- 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
- 768 – REIMBURSED PER O/P FG AT 130%. SEPARATE REIMBURSEMENT FOR IMPLANTABLES (INCLUDING CERTIFICATION) WAS REQUESTED PER RULE 134.403(G)
- 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.
- 892 – DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE INCLUDING CURRENT CPT CODE DESCRIPTIONS/INSTRUCTIONS.
- 897 – SEPARATE REIMBURSEMENT FOR IMPLANTABLES MADE IN ACCORDANCE WITH DWC RULE CHAPTER 134: SUBCHAPTER (E) HEALTH FACILITY FEES
- 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 amniotic stem cell allograft (HCPCS code C1765) experimental or investigational?
2. Does the amniotic stem cell allograft (HCPCS code C1765) qualify as an implantable?
3. What is the recommended payment amount for the services in dispute?
4. What is the additional recommended payment for the implantable items in dispute?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied payment for "AMNIOTIC FLUID XCEED PUR," as listed on the itemized statement, and described on the invoice as "XCEED Frozen Liquid allograft."

   The explanation of benefits (EOB) indicates payment denial is based on claim adjustment reason code:

   - 55 – PROCEDURE/TREATMENT IS DEEMED EXPERIMENTAL/INVESTIGATIONAL BY THE PAYER.

   Review of the submitted information finds no documentation to discuss or support that the disputed item is considered experimental or investigational.

   Whether an item is investigational or experimental may only be determined 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. For that reason, the carrier's denial regarding "deemed experimental/investigational" is not supported.

2. The insurance carrier denied payment for items billed under HCPCS code C1765 with adjustment 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.
   - 892 – DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE INCLUDING CURRENT CPT CODE DESCRIPTIONS/INSTRUCTIONS.

The respondent's position statement asserts, "The HCPCS definition of C1765 is adhesion barrier…. Neither the definition of C1765 nor the manner in which it was used operatively … supports the billing of it as an implant."

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, and (E) related equipment necessary to operate, program and recharge the implantable.

Rule §134.404(d) requires that, for coding, billing, reporting, and reimbursement of covered health care, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in the rule.

Medicare payment policies define HCPCS code C1765 as "adhesion barrier," and further address the use of code C1765 in the *List of Device Category Codes for Present or Previous Pass-Through Payment and Related Definitions*, Effective: January 1, 2016 (www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Complet-list-DeviceCats-OPPS.pdf), where Medicare describes the item as "A bioresorbable substance placed on and around the neural structures, which inhibits cell migration (fibroblasts) and minimizes scar tissue formation."

Review of the requestor's operative report finds documentation to support:

- The preoperative diagnosis includes adhesion of tendon to neurovascular bundle.
- The surgeon observed an extensive amount of scar tissue present in the operative field.
- The surgeon notes the biceps tendon was retracted 6cm, encased with scar tissue.
- The surgeon notes further the tendon stump was adhered to a neurovascular bundle.
- The surgeon performed neurolysis of the neurovascular bundle involving the median nerve.
- The surgeon performed extensive debridement of the tendinosis.
- The surgeon notes the bicipital tuberosity on the proximal radius … was freed of any soft tissue, taking care to protect the posterior interosseous nerve.
- The repair was then reinforced with injection of 1.5 mL of amniotic stem cell allograft for soft tissue reinforcement.

Based on the submitted medical records, the division finds sufficient information to support the disputed item to be a bioresorbable substance used as an adhesion barrier that was implanted, embedded, inserted or otherwise applied to neural structures in accordance with and for the purposes described in Medicare's payment policies regarding device category code C1765. The submitted documentation supports device code C1765 as billed. The division concludes the item meets the definition of an "implantable" in accordance with Rule §134.404(b)(2).

The insurance carrier's above denial reasons are not supported. The disputed implantable item will therefore be reviewed for additional reimbursement in accordance with division rules and fee guidelines.

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 modified by division rules.

   Review of the submitted information finds the provider requested separate payment for implants. Accordingly, per Rule §134.403(f)(1)(B), the facility specific amount (including outlier payments) is multiplied by 130 percent. Per Rule §134.403(f)(2), when calculating outlier payments, the facility's total billed charges shall be reduced by the billed charges for any item reimbursed separately under Rule §134.403(g). The charges for payable implants total $8,520.00. The total billed charges are reduced by this amount in calculating any outlier payment.

   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:

- HCPCS codes C1713 and C1765 represent implanted items with status indicator N denoting packaged codes under Medicare policy — but which are paid separately under division rules upon request in accordance with Rule §§ 134.403 (f) and (g). Payment for separately reimbursed implants is calculated below.
- Procedure codes 36415, 80048, 85025 and 85025 have status indicator Q4 denoting packaged laboratory services. Payment for these services is included in the reimbursement for the primary services.
- Per Medicare policy regarding Correct Coding Initiative (CCI) edits, procedure code 82947 may not be reported with code 80048, billed on the same date. Reimbursement for this service is included in the payment for code 80048. Separate reimbursement is not recommended.
- Procedure code 24342 has status indicator T, a significant outpatient procedure subject to multiple-procedure payment reduction. This code is assigned APC 5122. The OPPS Addendum A rate is $2,395.59. This is multiplied by 60% for an unadjusted labor amount of $1,437.35, in turn multiplied by the facility's annual wage index of 0.9731 for an adjusted labor amount of $1,398.69. The non-labor portion is 40% of the APC rate, or $958.24. This service does not meet the threshold for outlier payment. The sum of the labor and non-labor portions is the Medicare facility specific amount of $2,356.93. This is multiplied by 130% for a MAR of $3,064.01.
- Procedure code 64721 has status indicator T, a significant outpatient procedure subject to multiple-procedure payment reduction. The highest paying status T procedure (above) is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This code is assigned APC 5431. The OPPS Addendum A rate is $1,392.56, which is multiplied by 60% for an unadjusted labor amount of $835.54, in turn multiplied by the facility's annual wage index of 0.9731. The adjusted labor amount is $813.06. The non-labor portion is 40% of the APC rate, or $557.02. This service does not meet the threshold for outlier payment. The sum of the labor and non-labor portions is $1,370.08. The Medicare facility specific amount, after applying the 50% multiple-procedure payment reduction, is $685.04. This is multiplied by 130% for a MAR of $890.55.
- Procedure codes J2250, J2405, J2795, J3010, J3010, and J7030 have status indicator N denoting packaged codes with no separate payment — these items are integral to the total service package; reimbursement is included in the payment for the primary services.

4. Additionally, the provider requested separate reimbursement of implantables. Rule §134.403(g) requires that "Implantables, when billed separately by the facility … 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 the following implantables:

   - HCPCS code C1765, identified in the itemized statement as "AMNIOTIC FLUID XCEED PUR" and labeled on the invoice as "XCEED Frozen Liquid Allograft," has a cost per unit of $7,500.00;
   - HCPCS code C1713, identified in the itemized statement as "SYSTEM IMPLNT ELBW TOGGL" and labeled on the invoice as "TLZP ELBOW IMPLANT SYS W/CANN," has a cost per unit of $1,020.00.

   The total net invoice amount (exclusive of rebates and discounts) is $8,520.00. 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 $852.00. The total recommended reimbursement amount for the implantable items is $9,372.00.

5. The total allowable reimbursement for the services in dispute (including the requested separate payments for implantable items) is $13,326.56. The insurance carrier paid $5,076.55. The amount remaining due to the requestor is $8,250.01. 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 $8,250.01.

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 $8,250.01, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

______________________	Grayson Richardson	March 8, 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.