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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
[redacted]

Respondent Name
Liberty Mutual Fire Insurance

MFDR Tracking Number
M4-17-2691-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
May 12, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "A request for reconsideration was submitted on 1/23/17 requesting Liberty Mutual re-review all supporting documentation and remit additional payment for Rev. Code 278 Implants."

Amount in Dispute: $66,255.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Implants were not paid separately as requested as all required information to support their use and cost was not submitted for consideration…Previously denied BioDfactor, AmnioFix and PRP(billed under revenue code 278) as The medical efficacy of this procedure has not been established (X667) and Pre-authorization was required, but not requested for this service per DWC Rule 134.600 (X170)."

Response Submitted by: Liberty Mutual Fire Insurance

SUMMARY OF FINDINGS

Date of Service	Disputed Services	Amount in Dispute	Amount Due
October 28, 2016	Revenue Code 278	$66,255.00	$66.255.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 28 Texas Administrative Code §133.307 of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §134.404 sets out the acute care hospital fee guideline for inpatient services.
2. Explanation of Benefits January 17, 2017 and March 21, 2017 state, in pertinent part:
   35 units of 278 were denied with reason codes:
   - B12 X023 – Payment for charge is not recommended without an invoice or documentation of cost
   - 193 – The charge for this procedure exceeds the fee allowance
   - W3 – The charges for this hospitalization have been reconsidered

1 Unit Bone Marrow Aspirate, 1 Unit BoiDFator X-Large, 1 Unit AmnioFix 4.0cm x 6.0cm were denied with reason codes:

- 56 X667 – The Medical efficacy of this procedure has not been established…
- 193 – The charge for this procedure exceeds the fee allowance
- W3 – The charges for this hospitalization have been reconsidered

Findings

The services in dispute are addressed in the Division's fee guideline for inpatient hospital services. The fee rule permits the admitting hospital to request separate reimbursement for implantables as an alternative to the standard reimbursement.[1] In this case, [redacted] properly indicated on its medical bill that it elected for payment under the alternative payment provision.[2]

Upon receipt of the medical bill, Liberty Mutual made a payment; however it denied the hospital's request for separate payment for the implantables.

Date of Service	Disputed Items	Units	Denial Reasons
10/28/16	278 Supply/Implants	35.00	No cost invoice was provided
10/28/16	278 Supply/Implants	3.00	The medical efficacy is not established

In the following analysis, the Division considers the evidence provided by the parties in order to determine whether payment is due for the implantables billed under revenue code 278. The payment made for the rest of the admission will not be discussed because it is not in dispute here.

1. Is Liberty Mutual's denial for lack of a cost invoice supported?

In regards to the 35 units of implantables that were denied because no cost invoice was provided, the Division finds evidence to support that [redacted] submitted a cost invoice at reconsideration and again submitted a cost invoice when it filed for medical fee dispute. The cost invoice provided meets the requirements of Rule §134.404 including the required certification of cost.

Liberty's denial for lack of documentation is not supported. For that reason, payment is recommended for these 35 items.

2. Is Liberty Mutual's "medical efficacy" denial supported?

It is response to medical fee dispute, Liberty Mutual argues that a preauthorization requirement in Rule §134.600 is triggered due to its assertion that the efficacy of 3 specific items has not been established.

> Previously denied BioDfactor, AmnioFix and PRP(billed under revenue code 278) as The medical efficacy of this procedure has not been established (X667) and Pre-authorization was required, but not requested for this service per DWC Rule 134.600 (X170)

In its statement, Liberty is referring to the following preauthorization requirement:

> §134.600 (p)(6) **[preauthorization is required for]** any investigational or experimental service or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care.

A denial for payment based on §134.600 (p)(6) cannot be simply asserted on an explanation of benefits. The carrier has the burden to present evidence to support its denial reason. In this case Liberty failed to present evidence that the service in dispute lacks sufficient scientific/clinical evidence to demonstrate efficacy, nor did it provide evidence that the service in dispute is not yet broadly accepted as the prevailing standard of care.

[1] 28 Texas Administrative Code §134.404

[2] 28 Texas Administrative Code §133.10 (f)(2)(QQ)

Furthermore, Liberty could have elected to perform utilization review as described in Texas Insurance Code §4201.002(13) to support its assertion; however the Division found no evidence that the carrier performed utilization review in the manner and within the timeframes required by 28 Texas Administrative Code §133.240.

Liberty Mutual failed to demonstrate how it reached a determination that Bone Marrow Aspirate, BoiDFator X-Large, or AmnioFix 4.0cm x 6.0cm are not efficacious. For that reason, Liberty Mutual's "medical efficacy" denial is not supported. As a result, payment is recommended for Bone Marrow Aspirate, BoiDFator X-Large, or AmnioFix 4.0cm x 6.0cm.

3. What is the total payment amount due?

Payment for the services in dispute is established in the Division's fee guideline rule at 28 Texas Administrative Code §134.404(g) which states:

> §134.404 (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.

Review of the certified cost invoice finds that the invoiced amount is $64,255. The hospital is eligible for the maximum add-on of $2,000 over that invoiced amount. This results in a total payment of $66,255 for the services in dispute.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due for the implantables in dispute. As a result, the amount ordered is $66,255.00.

ORDER

The division hereby ORDERS Liberty Mutual Fire Insurance to remit $66,255.00 plus applicable accrued interest to [redacted] due within 30 days of receipt of this order.

Authorized Signature

	Martha P Luévano	July , 2018
Signature	Director for Medical Fee Dispute Resolution	Date

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, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

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 party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **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.