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
PINE CREEK MEDICAL CENTER

Respondent Name
LIBERTY MUTUAL INSURANCE CORP.

MFDR Tracking Number
M4-18-0226-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
September 25, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Shoulder injection of liquid amnion . . . a non-acquired, non-bovine, liquid amniotic biologic medically necessary when all other modalities have failed."

Amount in Dispute: $4,284.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Because the provider failed to submit all of this information on the original bill, the Payer reimbursed the provider at the implant included rate of 200%. The Payer upheld this payment rate on the . . . appeals as the requirement set forth in the fee schedule was not followed on the initial or first bill submission."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
June 2, 2017	Revenue Code 278: Implants – liquid amnion	$4,284.50	$0.00

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 acute care hospital fee guideline for outpatient services.
3. The insurance carrier denied payment for disputed Revenue Code 278 with claim adjustment reason code:
   - X667 – THE MEDICAL EFFICACY OF THIS PROCEDURE HAS NOT BEEN ESTABLISHED. FOR TEXAS JURISDICTION CLAIMS ONLY, PER TEXAS LABOR CODE SECTION 413.031 AND 28 TEX. ADMIN. CODE SECTIONS 133.308(H),(1), AFTER RECONSIDERATION, YOU MAY SEEK REVIEW OF A DENIAL OF MEDICAL NECESSITY THROUGH A TDI-DWC-APPOINTED INDEPENDENT REVIEW ORGANIZATION. THE FORM TO INITIATE THIS PROCESS CAN BE OBTAINED FROM THE DIVISION WEBSITE AT WWW.TDI.STATE.TX.US AND MUST BE SENT VIA FAX TO 603-334-8064.

Issues

1. Does “liquid amnion” meet the definition of an “implantable” according to division fee guidelines?
2. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards payment for an implanted medical substance or supply billed under Revenue Code 278 by an outpatient acute care hospital facility asserting that reimbursement is due under 28 Texas Administrative Code §134.403(g) — which requires that Implantables, when billed separately by the facility in accordance with Rule §134.403(f)(1)(B), “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."

   Rule §134.403(f)(B) further requires that if a facility requests separate payment of implantables, the Medicare facility specific amount (including outlier payments) is multiplied by 130 percent.

   The insurance carrier paid the bill at the 200% all-inclusive rate—without separate reimbursement of implants.

   While the health care provider did request separate reimbursement of implantables, the requestor did not support the disputed supply meets the definition of an implantable under Rule §134.403(b)(2) — which defines an 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.

   The disputed supply is a liquid and a biological substance — described in the requestor’s position statement as “liquid amnion.” It is further described in the operative report as “non-acquired, non-bovine, liquid amniotic biologic.” The invoice labels the substance “OrthoFlo 2.0 mL.”

   Despite being surgically applied (the operative report states the substance was injected into the tendon and joint), the division finds the disputed substance is not an “object,” but rather a liquid. Neither was any information presented to support its use as a “device.” Consequently, the provider has failed to support that the disputed substance meets the definition of an “implantable” in accordance with the requirements of the fee guideline. Accordingly, separate reimbursement cannot be recommended.

2. As no other items were billed that are reimbursable as implantables under the fee guideline, the insurance carrier’s payment at the all-inclusive rate of 200% of the Medicare facility specific amount was appropriate. Additional payment is therefore not 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 would like to emphasize that the findings and decision in this dispute are based on the available evidence presented by the requestor and respondent at the time of review. Even though not all the evidence was discussed, it was considered.

The requestor sought separate reimbursement of implantables; however, the requestor did not support that liquid amnion meets the definition of an implantable under division rules. As no other implantable items were billed, the insurance carrier’s payment at the all-inclusive percentage of 200% was appropriate, and no additional amount is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	March 9, 2018
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, 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 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.