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
SAINT CAMILLUS MEDICAL CENTER

Respondent Name
INDEMNITY INSURANCE COMPANY OF NORTH AMERICA

MFDR Tracking Number
M4-18-4122-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
June 26, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Authorization was obtained for Saint Camillus Medical Center…. Saint Camillus Medical Center requested Separate Reimbursement of Implants. The Invoices were under paid by using the Usual & Customary Prices."

Amount in Dispute: $10,263.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the following items were found to be payable as implantables … [see below] The following items were determined to be supplies and did not meet the definition of implantables … [see below] The item billed as amniofix 2 x 4 cm is considered investigational and not reimbursable … The invoices submitted by Saint Camillus reflect costs far above industry standard pricing for the items billed … ForeSight utilized industry standard pricing when determining reimbursement for the provider and applied a 10% mark-up … not only does Saint Camillus's invoicing exceed industry standards, it also violates the Prudent Buyer Principle as contemplated in the Texas Administrative and Labor Codes."

Response Submitted by: Foresight Implant Cost Containment

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 8, 2017	Inpatient Hospital Services with Implants	$10,263.25	$7,309.49

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 §134.404 sets out the hospital facility fee guideline for inpatient services.
3. Texas Insurance Code §4201.002 defines words and terms related to utilization review.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 94 – Processed in Excess of charges.
   - BOBC – The recommended allowance on this line is based on TX fee schedule reimbursement guidelines which allows greater than the providers billed charges.
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - P302 – The pricing and payment of this line is included in the room and board reimbursement.
   - W3 – Request for reconsideration.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer contractor.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 1 – Reimbursement based on the manufacturer's geo-specific true invoice cost for the product construct.
   - 4 – This item was determined to be a supply/non-implantable item.
   - 91 – The item billed has determined to be non-reimbursable.
     - With additional payment remark: The items has been identified as investigational, contraindicated, and/or not required for this procedure.
   - 26957 – CV RECONSIDERATION – NO ADDITIONAL ALLOWANCE RECOMMENDED. THIS BILL AND SUBMITTED DOCUMENTATION HAVE BEEN RE-EVALUATED BY CLINICAL VALIDATIO
   - 26951 – ADDITIONAL ALLOWANCE IS NOT RECOMMENDED AS THIS BILL WAS REVIEWED IN ACCORDANCE WITH STATE GUIDELINES USUAL AND CUSTOMARY POLICIES, OR THE P

Issues

1. Is Amniofix amniotic membrane reimbursable as an implantable item?
2. Is a bone marrow aspirate kit reimbursable as an implantable item?
3. Has the respondent waived any new defenses or denial reasons not presented to the provider before MFDR?
4. What is the recommended payment for the facility services in dispute?
5. What is the additional recommended payment for the implantable items in dispute?
6. Is the requestor entitled to additional payment?

Findings

1. The insurance carrier denied payment for "IMP AMNIOFIX 2X4CM (UNI-INSTR)," as listed on the itemized statement, and described on the invoice as "Amniofix Amniotic Membrane Allograf 2'X4'."

   The explanation of benefits (EOB) lists claim adjustment reason code:

   - 91 – The item billed has determined to be non-reimbursable.
     With additional payment remark:
     - The items has been identified as investigational, contraindicated, and/or not required for this procedure.

   The respondent's position statement asserts that "The item billed as amniofix 2 x 4 is considered investigational and not reimbursable (Exhibit B)." The respondent's Exhibit B is an excerpt from 28 Texas Administrative Code §134.404, the division's hospital facility fee guideline for inpatient services.

   Review of the submitted information finds no documentation that discusses or supports that Amniofix is considered investigational.

   The determination of a service's investigational or experimental 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. For that reason, the carrier's denial relating to Amniofix's "investigational" nature is not supported.

   Review of the submitted information finds that the insurance carrier failed to support this denial reason. The disputed services will therefore be reviewed in accordance with applicable division rules and fee guidelines.

2. The insurance carrier denied payment for "IMP BONE MARROW ASPIRATE KIT," as listed on the itemized statement, described on the invoice as "ART BMC Processing Kit (without back chamber)."

   The explanation of benefits (EOB) lists claim adjustment reason code 4 – "This item was determined to be a supply/non-implantable item" as the rationale for payment denial.

   The respondent's position statement asserts that this item was "determined to be supplies and did not meet the definition of implantables."

   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.

   Review of the submitted documentation finds insufficient documentation to support that this item was implanted or meets the definition of an implantable under §134.403(b)(2). The kit was used to remove bone marrow cells from the injured employee and prepare them as an autograft for reinsertion into the patient's own body at another site. The inserted item is not an object or device, but rather a biological substance or tissues obtained from the injured employee — not purchased from a manufacturer or supplier. Nothing in the kit itself was implanted, embedded, inserted or otherwise applied to the patient, nor does the kit constitute related equipment necessary to operate, program or recharge an implanted item.

   The division finds the insurance carrier's denial reason to be supported. Separate reimbursement is not recommended for this item.

3. The respondent's position statement raises new defenses or denial reasons that were not previously presented to the health care provider during bill review, reconsideration or before the request for medical fee dispute resolution.

   Rule §133.307(d)(2)(F) requires that the response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

   The insurance carrier's failure to give notice to the health care provider of such defenses or denial reasons constitutes grounds for the division to find a waiver of defenses during Medical Fee Dispute Resolution; and the division finds such a waiver here.

   The respondent raised new denial reasons or defenses in the response of which the carrier failed to give any notice to the health care provider during the bill review process or prior to the filing of this dispute. Consequently, the division concludes the insurance carrier has waived the right to raise these new denial reasons or defenses during MFDR. Any such new defenses or denial reasons will not be considered in this review.

4. This dispute regards inpatient services with payment subject to the *Hospital Facility Fee Guideline—Inpatient*, Rule §134.404, requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount (including outlier payments) applying Medicare Inpatient Prospective Payment System (IPPS) formulas and factors published in the Federal Register, with modifications set out in the rule. Medicare IPPS formulas and factors are available from the Centers for Medicare and Medicaid Services at http://www.cms.gov.

   The hospital requested separate reimbursement for implantables; accordingly, Rule §134.404(f)(1)(B) requires that reimbursement shall be the Medicare facility specific amount, including any outlier payment, multiplied by 108%.

   Per Rule §134.404(f)(2), when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under Rule §134.404(g).

   The facility's billed charges for the separately reimbursed implantable items total $105,445.00. Accordingly, the facility's total billed charges are reduced by this amount when calculating any outlier payment.

   The division calculates the Medicare facility specific amount using Medicare's *Inpatient PPS PC Pricer* as a tool to efficiently identify and apply IPPS formulas and factors. This software is also freely available from www.cms.gov.

   Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 472. The service location is Hurst, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $16,686.33. This amount multiplied by 108% results in a MAR of $18,021.24.

5. The provider also requested separate reimbursement of implanted items.

   Rule §134.404(g), requires that:

   > "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 submitted documentation finds that the separate implantables include:

   - "IMP MAXIS PLT 34MM 2-LVL CERV" as identified in the itemized statement and labeled on the invoice as "2-Level 34mm Cervical Plate" with a cost per unit of $3,900.00;
   - "14M VARIABLE SCREW" as identified in the itemized statement and labeled on the invoice as "Self-Drilling Variable Screw 4.0x 14mm" with a cost per unit of $500.00 at 6 units, for a total cost of $3,000.00;
   - "STERISORB CUBE 10MM" as identified in the itemized statement and labeled on the invoice as "10 mm SteriSorb Cube" with a cost per unit of $895.00 at 2 units, for a total cost of $1,790.00;
   - "DBM PUTTY 1CC" as identified in the itemized statement and labeled on the invoice as "1CC Putty" with a cost per unit of $370.00;
   - "IMP AMNIOFIX 2X4CM (UNI-INSTR)" as identified in the itemized statement and labeled on the invoice as "Amniofix Amniotic Membrane Allograf 2'X4' "with a cost per unit of $3,495.00;
   - "6MM UCERV CERV INTERBODY" as identified in the itemized statement and labeled on the invoice as "uCerv, Small-cervical Titanium Interbody height, 6mm (14mm x 12mm) 6°" with a cost per unit of $4,267.00;
   - "7MM UCERV CERV INTERBODY" as identified in the itemized statement and labeled on the invoice as "uCerv, Small-cervical Titanium Interbody height, 7mm (14mm x 12mm) 6°" with a cost per unit of $4,267.00.

   Additionally, the provider billed "IMP BONE MARROW ASPIRATE KIT" as identified in the itemized statement and labeled on the invoice as "ART BMC Processing Kit (without back chamber)"; however, as found above, this item did not meet the definition of an implantable; thus, separate reimbursement is not recommended.

   Rule §134.404(f)(2) requires that when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.404(g).

   The facility's total billed charges for the separately reimbursed implantable items are $105,445.00; accordingly, this amount has been deducted from the total billed charges in calculating the Medicare hospital facility payment.

   The total net invoice amount (exclusive of rebates and discounts) is $21,089.00. 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 $2,000.00. The total recommended reimbursement amount for the implantable items is $23,089.00.

6. The total recommended reimbursement for the services in dispute (including separately reimbursed implanted items) is $41,110.24. The insurance carrier paid $33,800.75. The amount due to the requestor is $7,309.49.

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 $7,309.49.

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 $7,309.49, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	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.