TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Crescent Medical Center

Respondent Name
Old Republic Insurance Co

MFDR Tracking Number
M4-22-0018-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
September 8, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 1, 2021	Rev Code 278 (Implant)	$1650.00	$1650.00
April 1, 2021	Rev Code 360 CPT 26236	$1810.06	$5.11
	Total	$3,460.06	$1,655.11

Requestor's Position

The requestor did not submit a position statement but submit a copy of their reconsideration which states, "The expected allowed amount was $3,460.06. The actual allowed was $1,767.48. Please reprocess and pay the additional $1,692.58."

Amount in Dispute: $3,460.06

Respondent's Position

Upon receipt of the MDR request, the bill as sent for reconsideration. The review determined that the provider is not due additional money.

Response Submitted by: ESIS

…in conclusion, this item does not meet the state's definition of an allowable implant. This item is deemed experimental by the FDA and is not reimbursable as billed.

Response Submitted by: Foresight

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.403 sets out the fee guidelines for [description].

Denial Reasons

The insurance carrier reduced / denied the payment for the disputed services with the following claim adjustment codes:

- ForeSight / 10 – Upon review of submitted request for reconsideration, ForeSight has determined that no additional allowance will be made
- ForeSight / 91 – The item billed has determined to be non-reimbursable. The items has been identified as investigational, contraindicated, and/or not required for this procedure
- ESIS / 131 – Claim specific negotiated discount
- ESIS / 18 – Duplicate claim/service
- ESIS / 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- ESIS / P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Is the insurance carrier's reduction supported?

2. Is the insurance carriers' denial supported?

3. What rule applies for determining reimbursement for the disputed services?

4. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment of a surgical procedure with implants preformed in April 2021. The insurance carrier reduced the payment as claim specific negotiated discount. Review of the submitted documentation found insufficient evidence to support the injured worker was enrolled in a certified network or evidence of a contract.
2. The insurance carrier's agent (ForeSight) denied the payment of the implants based on the items having been identified as investigational, contraindicated, and/or not required for this procedure

   The division notes that 28 TAC §137.100 (e) sets out the appropriate administrative process for the carrier to retrospectively review reasonableness and medical necessity of care already provided. Section (e) states:

   "An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017."

   Retrospective review is defined in 28 TAC §19.2003 (28) as "The process of reviewing health care which has been provided to the injured employee under the Texas Workers' Compensation Act to determine if the health care was medically reasonable and necessary."

   DWC Rule 28 TAC §19.2015(b) titled Retrospective Review of Medical Necessity states: (b) When retrospective review results in an adverse determination or denial of payment, the utilization review agent shall notify the health care providers of the opportunity to appeal the determination through the appeal process as outlined in Chapter 133, Subchapter D of this title which requires the prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor."

   The division finds that the carrier failed to follow the appropriate administrative process to address the assertions made in its response to this medical fee dispute. The insurance carrier's denial will not be considered in this dispute.
3. DWC Rule 28 TAC §134.403 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

   The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.1. Specifically, Payment Status Indicators and Ambulatory Payment Category (APC).

   DWC Rule 28 TAC 134.403 (f) states in pertinent part the reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*. Separate reimbursement for the implant was

requested. The Medicare facility specific amount will be multiplied by 130 percent.

The Medicare facility specific amount is calculated when the APC payment rate is multiplied by 60% to determine the labor portion. This amount is multiplied by the facility wage index for the date of service. The non-labor amount is determined when the APC payment rate is multiplied by 40%. The sum of the labor portion multiplied by the facility wage index and the non-labor portion determines the Medicare specific amount. Review of the submitted medical bill and the applicable fee guidelines referenced above is shown below.

- Procedure code 26236 has status indicator J1 is assigned APC 5112. The OPPS Addendum A rate is $1,392.35. This is multiplied by 60% for an unadjusted labor amount of $835.41, in turn multiplied by facility wage index 0.9655 for an adjusted labor amount of $806.59.

  The non-labor portion is 40% of the APC rate, or $556.94.

  The sum of the labor and non-labor portions is $1,363.53.

  The Medicare facility specific amount is $1,363.53 multiplied by 130% for a MAR of $1,772.59.

- The billed implant "Barrier Tissue Hydrobex 1ml" was identified in the itemized statement and labeled on the invoice as "Hydrobex 1ml Tissue Barrier" with a cost per unit of $1,500.00.

  The total net invoice amount (exclusive of rebates and discounts) is $1,500.00. 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 $150.00. The total recommended reimbursement amount for the implantable items is $1,650.00.

4. The total recommended reimbursement for the disputed services is $3,422.59. The insurance carrier paid $1,767.48. The amount due is $1,655.11. This amount is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement of $1,655.11 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Old Republic Insurance Co must remit to Crescent Medical Center $1,655.11 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		October 14, 2021
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.