



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 SURGICAL HOSPITAL AT TROPHY CLUB

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number

M4-17-2054-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

March 6, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim . . . was not processed according to Texas fee guidelines for outpatient services. . . . Partial reimbursement was received from the Respondent. Reconsideration was submitted with no response received."

Amount in Dispute: \$4,746.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor's invoice for the alleged implantable identifies the implant as Paligen Flo, an amniotic membrane. . . . Because amniotic membrane is not consistent with the definition above Texas Mutual declined to issue payment. . . . the operative report does not document the use of Paligen Flow."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Dispute Amount, Amount Due. Row 1: June 14, 2016, Outpatient Hospital Services, \$4,746.56, \$1,838.10

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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. Texas Insurance Code §1305.153 sets out payment provisions regarding network and non-network providers.
4. The requestor is a non-network provider that rendered pre-approved services to a network claimant in accordance with Texas Insurance Code §1305.153(c), which requires that out-of-network providers shall be reimbursed as provided by the Texas Workers' Compensation Act and division rules.

5. 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.
 - 198 – PRECERTIFICATION/AUTHORIZATION EXCEEDED.
 - 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.
 - 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.
 - 616 – THIS CODE HAS STATUS Q APC INDICATOR AND IS PACKAGED INTO OTHER APC CODES THAT HAVE BEEN IDENTIFIED BY CMS.
 - 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
 - 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
 - 761 – SERVICE CONSIDERED EXPERIMENTAL AND/OR INVESTIGATIONAL THEREFORE PREAUTHORIZATION IS REQUIRED.
 - 768 – REIMBURSED PER O/P FG AT 130%. SEPARATE REIMBURSEMENT FOR IMPLANTABLES (INCLUDING CERTIFICATION) WAS REQUESTED PER RULE 134.403(G)
 - 770 – IMPLANT PROVIDER CHARGES DENIED PER OUTPATIENT FG. REQUIRED CERTIFICATION NOT INCLUDED PER RULE 134.403(G)(1)
 - 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.
 - P12 – WORKERS’ COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.

Issues

1. Are the disputed services considered “experimental and/or investigational”?
2. Is the item billed under HCPCS code C1762 separately payable as an implantable?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied HCPCS code C1762 based on claim adjustment reason codes:

- 55 – PROCEDURE/TREATMENT IS DEEMED EXPERIMENTAL/INVESTIGATIONAL BY THE PAYER.
- 761 – SERVICE CONSIDERED EXPERIMENTAL AND/OR INVESTIGATIONAL THEREFORE PREAUTHORIZATION IS REQUIRED.

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 HCPCS code C1762 based on claim adjustment reason 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.

The respondent’s position statement asserts:

“The requestor’s invoice for the alleged implantable identifies the implant as Paligen Flo, an amniotic membrane. . . . Because amniotic membrane is not consistent with the definition above Texas Mutual declined to issue payment. . . . the operative report does not document the use of Paligen Flow.”

Rule §134.403(b)(2) defines "implantable" as an object or device that is surgically: (a) implanted, (b) embedded, (c) inserted, (d) or otherwise applied ...

The disputed item is described on the invoice as "Palligen Flow." The operative report notes that "1 ml of allograft tissue was then injected around the A1 pulley to prevent adhesion and scar formation." No further information was provided by the requestor to describe or support the Palligen Flow or allograft tissue injected.

Although, as a liquid, the item does not qualify as an "object" under the division's definition of an implantable, it may still meet the criteria if used as a "device."

Rule §134.403(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 C1762 as "Connective tissue, human," and address the use of this code in the *List of Device Category Codes for Present or Previous Pass-Through Payment and Related Definitions*, (www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Complelist-DeviceCats-OPPS.pdf), where Medicare explains "These tissues include a natural, cellular collagen or extracellular matrix obtained from autologous rectus fascia, decellularized cadaveric fascia lata, or decellularized dermal tissue. They are intended to repair or support damaged or inadequate soft tissue. They are used to treat urinary incontinence resulting from hypermobility or Intrinsic Sphincter Deficiency (ISD), pelvic floor repair, or for implantation to reinforce soft tissues where weakness exists in the urological anatomy." The policy does not require the tissues to be a solid substance.

However, review of the documentation submitted by the provider finds insufficient information to support that the item was used as a device or meets the definition of code C1762 in accordance with Medicare payment policies. The operative report does not document that the item was used to repair or intended to support damaged or inadequate soft tissue. The anatomical site of injection was the thumb. The documentation does not support use of the item to treat the urological anatomy or pelvic region.

The division concludes the requestor's documentation is insufficient to support the item as billed or that the item meets the definition of an implantable in accordance with Rule §134.403(b)(2).

The insurance carrier's denial reasons are supported. Additional payment for code C1762 is not recommended.

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 DWC rules.

Rule §134.403(f)(1) requires the Medicare facility specific amount and any outlier payment be multiplied by 200% unless separate payment for implants is requested in accordance with Rule §134.403(g).

Although separate payment for implants was requested, as no qualifying implants were found eligible and no such items were separately paid in accordance with Rule §134.403(g), reimbursement for the services is calculated in accordance with Rule §134.403(f)(1), which requires the Medicare specific facility amount be multiplied by 200%.

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:

- Procedure code C1762 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary service.
- Procedure codes 36415, 80048, 81025, and 85025 have status indicator Q4, denoting packaged labs; reimbursement is included in the APC payment for the primary services.
- Per Medicare policy, procedure code 82947 may not be reported with procedure code 80048 billed on the same claim. Reimbursement for this service is included with payment for code 80048.

- Procedure code 26055 has status indicator T, denoting a significant outpatient procedure assigned APC 5121. The OPSS Addendum A rate is \$1,455.26. This is multiplied by 60% for an unadjusted labor amount of \$873.16, in turn multiplied by the facility wage index of 0.9731 for an adjusted labor amount of \$849.67. The non-labor portion is 40% of the APC rate, or \$582.10. The sum of the labor and non-labor portions is \$1,431.77. Per 42 Code of Federal Regulations §419.43(d) and *Medicare Claims Processing Manual*, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost of a service exceeds 1.75 times the OPSS payment and also exceeds the fixed-dollar threshold of \$3,250, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPSS payment. Per the OPSS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider in 2016 as 0.313. This ratio multiplied by the billed charge of \$4,635.00 yields a cost of \$1,450.76. The total cost of packaged items is allocated to the primary OPSS services. The sum of packaged costs is \$1,890.70. This amount is added to the service cost for a total cost of \$3,341.46. The cost of services exceeds the fixed-dollar threshold of \$3,250. The amount by which the cost exceeds 1.75 times the OPSS payment is \$835.86. 50% of this amount is \$417.93. The Medicare facility specific amount (including outlier payment) of \$1,849.70 is multiplied by 200% for a MAR of \$3,699.40.
- Procedure codes J0131, J0690, J2250, J2405, and J3010 have status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
- Procedure code 93005 has status indicator Q1, denoting STV-packaged codes; reimbursement for these services is packaged with the payment for the primary procedure above, which has status indicator T.

The total recommended reimbursement for the disputed services is \$3,699.40. The insurance carrier paid \$1,861.30, leaving an amount due to the requestor of \$1,838.10. This amount is recommended.

Conclusion

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 \$1,838.10.

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 \$1,838.10, 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, 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.