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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Neurosurgical Associates

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-14-1381-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
January 17, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This patient was admitted to ICU at St. Joseph's Hospital emergently on 7/19/13. Dr. Kakarla was called for neurosurgical consultation based on radiology studies performed subsequent to admission. Pt was taken emergently to surgery on 7/20/13. Per admitting staff at St. Joseph's when they called to verify pt's coverage with Medicare they were told that pt has an open workers compensation claim. When they called Texas Mutual to verify claim and benefits they were told that 'no preauth is required for emergent admission'. Our staff called Texas Mutual on 7/24/13 to verify claim and benefits and we were told that pt 'has an open claim for his lumbar spine with lifetime medical benefits related to injury of 5/10/95'. There was NO indication that pre-auth was required for treatment. Our claim was submitted on 7/29/13 with a copy of the operative report. We received a letter on 8/20/13 (dated 8/5/13) requesting 'identity of employer' and 'date of injury'. Claim was resubmitted on 8/20/13 with the requested information. We received an EOB on 10/8/13 with denial CAC-197 – 'Precertification/authorization/notification absent'. We field a Request for Reconsideration on 10/29/13 and indicated that exas Mutual WAS notified on 7/20/13 of surgery and proposed CPT codes. We received an EOB on 12/3/13 with denial code CAC-193 'original payment decision is being maintained'.

Our position is that Dr. Kakarla deserves to be paid for the neurosurgical services rendered to this pt because he was admitted and surgery was performed emergently so we were not aware of this case until 7/24/13. Based on our communications with the hospital and Texas Mutual we were never informed that precertification was required, only that the pt DID have an 'open workers compensation case for his lumbar spine with lifetime medical support'. Dr. Kakarla cannot be held liable for what the hospital staff does or does not do to certify a patient's admission when he is called to respond emergently. His surgical care for this patient was appropriate based on his presenting symptoms and radiographic findings. His treatment met standard of care guidelines, was rendered in good faith and he deserves to be compensated for this surgery."

Amount in Dispute: $19,600.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 7/20/13.

…the services provided on 7/20/13 were not preauthorized as reflected by the EOBs. Texas Mutual maintains its position no payment is due absent preauthorization."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 20, 2013	Spinal surgery	$19,600.00	$8,089.57

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 §134.600 sets out the procedures for services that require preauthorization.
3. 28 Texas Administrative Code §133.2 provides the definitions that apply to medical services.
4. 28 Texas Administrative Code §134.203 sets out the fee guidelines for billing and reimbursing professional medical services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-197 – Precertification/authorization/notification absent.
   - CAC-97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 284 – No allowance was recommended as this procedure has a Medicare status of 'B' (Bundled).
   - 930 – Pre-authorization required, reimbursement denied.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 891 – No additional payment after reconsideration.

Issues

1. Under what authority is the request for medical fee dispute resolution considered?
2. Was preauthorization required for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor is a health care provider that rendered disputed services in the state of Arizona to an injured employee with an existing Texas Workers' Compensation claim. The health care provider was dissatisfied with the insurance carrier's final action. The health care provider requested reconsideration from the insurance carrier and was denied payment after reconsideration. The health care provider has requested medical fee dispute resolution under 28 Texas Administrative Code §133.307. Because the requestor has sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the Division concludes that it has jurisdiction to decide the issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable rules.
2. The insurance carrier denied services stating, "Precertification/authorization/notification absent." 28 Texas Administrative Code §134.600 (c) states, "The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions)." 28 Texas Administrative Code §133.2 (5)(A)defines an emergency stating, "a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or **bodily functions** in serious jeopardy, or (ii) **serious dysfunction** of any body organ or part" [emphasis added].

   Review of the medical records finds that the injured employee presented to the emergency room with "**urinary incontinence** for approximately 2-3 weeks…He clearly has iatrogenic flat back… He developed adjacent segment **kyphotic deformity** at L2-3 and L1-2. The patient has global lumbar kyphosis. An MRI also reveals **significant stenosis** and **complete blockage of spinal fluid** at L1-L2 and L2-3…Based on imaging evaluation, he **required emergent decompression** of L1-2 and L2-3" [emphasis added]. Therefore, the procedure meets the definition of an emergency in 28 Texas Administrative Code §133.2 (5)(A), which does not require preauthorization.

3. The insurance carrier has not supported denial of the disputed services based on absent preauthorization. Therefore, the requestor is entitled to reimbursement.

   Procedure code 22633, service date July 20, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 27.75 multiplied by the geographic practice cost index (GPCI) for work of 1 is 27.75. The practice expense (PE) RVU of 19.45 multiplied by the PE GPCI of 0.978 is 19.0221. The malpractice RVU of 7.35 multiplied by the malpractice GPCI of 1.015 is 7.46025. The sum of 54.23235 is multiplied by the Division conversion factor of $69.43 for a MAR of $3,765.35.

   Procedure code 22842, service date July 20, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 12.56 multiplied by the geographic practice cost index (GPCI) for work of 1 is 12.56. The practice expense (PE) RVU of 6.53 multiplied by the PE GPCI of 0.978 is 6.38634. The malpractice RVU of 3.44 multiplied by the malpractice GPCI of 1.015 is 3.4916. The sum of 22.43794 is multiplied by the Division conversion factor of $69.43 for a MAR of $1,557.87.

   Procedure code 22851, service date July 20, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 6.7 multiplied by the geographic practice cost index (GPCI) for work of 1 is 6.7. The practice expense (PE) RVU of 3.47 multiplied by the PE GPCI of 0.978 is 3.39366. The malpractice RVU of 1.89 multiplied by the malpractice GPCI of 1.015 is 1.91835. The sum of 12.01201 is multiplied by the Division conversion factor of $69.43 for a MAR of $833.99.

   Procedure code 22614, service date July 20, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 6.43 multiplied by the geographic practice cost index (GPCI) for work of 1 is 6.43. The practice expense (PE) RVU of 3.34 multiplied by the PE GPCI of 0.978 is 3.26652. The malpractice RVU of 1.77 multiplied by the malpractice GPCI of 1.015 is 1.79655. The sum of 11.49307 is multiplied by the Division conversion factor of $69.43 for a MAR of $797.96.

   Procedure code 20930, service date July 20, 2013, has a status indicator of B, which denotes a bundled code. Payments for these services are always bundled into payment for other services to which they are incident.

   Procedure code 20936, service date July 20, 2013, has a status indicator of B, which denotes a bundled code. Payments for these services are always bundled into payment for other services to which they are incident.

   Per Correct Coding Initiative Edits in Medicare policy, procedure code 63047, service date July 20, 2013, may not be reported with procedure code 22633 billed on this same claim. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. The provider billed the disputed service with an appropriate modifier. Separate payment is allowed. Procedure code 63047 represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 15.37 multiplied by the geographic practice cost index (GPCI) for work of 1 is 15.37. The practice expense (PE) RVU of 13.12 multiplied by the PE GPCI of 0.978 is 12.83136. The malpractice RVU of 4.41 multiplied by the malpractice GPCI of 1.015 is 4.47615. The sum of 32.67751 is multiplied by the Division conversion factor of $69.43 for a MAR of $2,268.80. Procedure code 63047 has a multiple procedure indicator of 2. Multiple Procedure Reduction Guidelines state that standard payment adjustment rules for multiple procedures apply. If the procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50% and by report). Base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount reduced by the appropriate percentage. Procedure code 22633 also has a multiple procedure indicator of 2 and this code has the higher fee schedule amount. Therefore, the total allowable for procedure code 63047 as billed is $1,134.40.

   The total allowable reimbursement for the services in dispute is $8,089.57. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $8,089.57. 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 $8,089.57.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $8,089.57 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	March 3, 2015
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 28 Texas Administrative Code §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 MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **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.