



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

Methodist Hospital

Respondent Name

Liberty Insurance Corp

MFDR Tracking Number

M4-14-3614-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

August 11, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Advent Health Partners is submitting a medical fee dispute resolution request on behalf of Methodist Hospital. We are in receipt of a denial for the above mentioned claim by Liberty Mutual for Medical Necessity. We are requesting that Texas Department of Insurance request that they reprocess this claim with the authorization that was obtained on 12-21-13, authorization number 9813761."

Amount in Dispute: \$45,821.35

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill and documentation attached to the medical dispute have been re-reviewed and our position remains unchanged. Our rationale is as follows: The Provider did not seek authorization as required under Title 28 under § Rule 134.600 which requires the provider to seek pre-authorization for non-emergency hospital services. The provider treated the claimant without requesting pre-authorization for treatment of a cervical spine fusion. ...The attached report does not support necessity for this procedure."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 24, 2013 to October 2, 2013	Inpatient Hospital Services	\$45,821.35	\$35,128.11

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 a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. 28 Texas Administrative Code §134.240 sets out guidelines for medical payments and denials.
4. 28 Texas Administrative Code §133.2 defines words and terms related to medical billing and processing.
5. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.

6. The services in dispute were reduced/denied by the respondent with the following reason codes:

- 388 – Pre-authorization was requested by denied for this service per DWC Rule 134.600
- 193 – Original payment decision is being maintained.

Issues

1. Did the respondent meet the requirements of Rule §134.240(q)?
2. Did the respondent raise and new denial reason?
3. Did the submitted documentation support the definition of an emergency?
4. Did the services in dispute require authorization?
5. Which reimbursement calculation applies to the services in dispute?
6. What is the maximum allowable reimbursement for the services in dispute?
7. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. The Carrier in their position statement states, “The attached report does not support necessity for this procedure.” 28 Texas Administrative Code §134.240(q) states, “(q) When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title (relating to Notice of Determinations Made in Utilization Review). Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title (relating to Requirements Prior to Issuing Adverse Determination), including the requirement that 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 or, in cases of a dental plan or chiropractic services, with a dentist or chiropractor, respectively.” Review of the submitted documentation found “Retrospective Management” report dated March 4, 2014 which is after the adverse determination was rendered on the Explanation of benefits and contained in the respondent’s position statement. Therefore, this denial will not be considered during this review. The Division will apply applicable fee guidelines in consideration of this dispute.
2. 28 Texas Administrative Code 133.307 (d)(2)(F)states, “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 Division concludes that the Carrier raised a new denial reason that shall not be considered in this review.”
3. 28 Texas Administrative Code 133.2 (5) states, “Emergency--Either a medical or mental health emergency as follows: (A) 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;” Review of the medical record finds;
 - a. Emergency Room Visit – “Back Pain - ...It is described as being severe (10/10).
 - b. Emergency Room Visit – “Upon discharge, pt was having severe pain and trouble ambulating into wheelchair. Will call IPC to admit pt for pain control”
 - c. Clinical note, “Massive L4/5 HNP with sever canal stenosis, cauda equine syndrome radiographically. He is workman’s comp, and as such it would take weeks to gain approval as an outpatient surgery might still be denied leaving him incontinent with irreversible neurological deficit.”

Based on the above the Division finds sufficient evidence to support the definition of an emergency has been met.

4. 28 Texas Administrative Code §134.600 (c) states in pertinent part, “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);” Therefore, the disputed services will be reviewed per applicable rules and fee guidelines.
5. 28 Texas Administrative Code §134.404(f) states that “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 Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

- (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
- (A) 143 percent; unless
 - (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent.”

No documentation was found to support that the facility requested separate reimbursement for implantables; for that reason the MAR is calculated according to 28 Texas Administrative Code §134.404(f)(1)(A).

6. 28 Texas Administrative Code §134.404(f)(1)(A) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at <http://www.cms.gov>. Documentation found supports that the DRG assigned to the services in dispute is 490, and that the services were provided at Methodist Hospital. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of \$24,565.11. This amount multiplied by 143% results in a MAR of \$35,128.11.
7. The division concludes that the total allowable reimbursement for the services in dispute is \$35,128.11. The respondent issued payment in the amount of \$0.00. Based upon the documentation submitted, additional reimbursement in the amount of \$35,128.11 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

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 \$35,128.11 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March , 2015 Date
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Signature	Medical Fee Dispute Resolution Manager	March , 2015 Date
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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.