



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

Houston Orthopedic Surgical Hospital

Respondent Name

Fidelity & Guaranty Insurance

MFDR Tracking Number

M4-15-1829-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

February 17, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We followed the proper protocol in this patient's care by obtaining authorization. We are asking that you reprocess our claim for payment."

Amount in Dispute: \$87,374.65

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No written position statement submitted.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: July 24 - 28, 2014, Inpatient Hospital Services, \$87,374.65, \$18,877.53

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. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged, received on February 25, 2015. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.404 sets out the acute care hospital fee guideline for inpatient services.

4. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 814 – Unnecessary medical treatments or services
  - 283 – Based on peer review, payment is denied because the treatment(s) /service(s) is medically unreasonable/unnecessary
  - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline

### **Issues**

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule for determining reimbursement of the disputed services?
3. What is the recommended payment for the services in dispute?
4. What is the additional recommended payment for the implantable items in dispute?
5. Is the requestor entitled to additional reimbursement?

### **Findings**

1. The insurance carrier denied disputed services with claim adjustment reason code 283 – “Based on a peer review, payment is denied because the treatment(s) /service(s) is medically unreasonable/unnecessary.” 28 Texas Administrative Code §134.600 (8) states “Preauthorization: a form of prospective utilization review by a payor or a payor's utilization review agent of health care services proposed to be provided to an injured employee.” Review of the submitted information finds;

- a. Review Determination from UMD dated 07/11/2014: Recommendation: Approval

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: (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care;” Based on the above the insurance carrier's denial reason is not supported. The above mentioned document from UniMed Direct states, “...the C3-4 anterior cervical discectomy and fusion for the adjacent segment disease as well as posterolateral decompression from C4 – 7 for ongoing radiculopathy is medically necessary.” The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. This dispute relates to facility medical services provided in an inpatient acute care hospital. No documentation was found to support that the services are subject to a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011. Reimbursement is therefore subject to the provisions of 28 Texas Administrative Code §134.404(f), which states that:

The reimbursement calculation used for establishing the MAR [maximum allowable reimbursement] 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.

Review of the submitted documentation finds that separate reimbursement for implantables was requested; for that reason, the MAR is calculated according to §134.404(f)(1)(B).

3. Per §134.404(f)(1)(B), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment by 108%. Information regarding the calculation of Medicare IPPS payment rates may be found at <http://www.cms.gov>. Review of the submitted documentation finds that the DRG code assigned to

the services in dispute is 473. The services were provided at Houston Orthopedic and Spine Hospital. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is \$12,930.28. This amount multiplied by 108% results in a MAR of \$13,964.70.

4. Additionally, the provider requested separate reimbursement of implantables. Per §134.404(g):

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:

- "surgiflo matric" as identified in the itemized statement and labeled on the invoice as "surgioflo/lyo" with a cost per unit of \$1,117.21;
- "mtf dbx putty 1cc" as identified in the itemized statement and labeled on the invoice as "dbx putty 1cc" with a cost per unit of \$204.00;
- "spmosaic plate" as identified in the itemized statement and labeled on the invoice as "3h cerv mosaic" with a cost per unit of \$2,620.00;
- "se var rescue screw" as identified in the itemized statement and labeled on the invoice as "sp 4.5x12mm vari st screw" with a cost per unit of \$175.00 at 3 units, for a total cost of \$525.00.
- The total net invoice amount (exclusive of rebates and discounts) is \$4,466.21. 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 \$446.62. The total recommended reimbursement amount for the implantable items is \$4,912.83.

5. The total allowable reimbursement for the services in dispute is \$18,877.53. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$18,877.53. 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 \$18,877.53.

### ***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 \$18,877.53 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

\_\_\_\_\_  
May 29, 2015  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Manager

\_\_\_\_\_  
May 29, 2015  
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 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 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.**