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
Universal DME LLC

Respondent Name
General Motors LLC

MFDR Tracking Number
M4-16-2349-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
April 11, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is also my understanding that a preauthorization is only required on items that are over $500 per line item in which these are not over the amount. We should be paid for services rendered because we have submitted the appropriate paperwork for review."

Amount in Dispute: $527.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The durable medical equipment in dispute in this matter was denied based on retrospective medical necessity. The peer review report is attached. The physician reviewed the surgical procedure the Claimant underwent on 12/30/15. The durable medical equipment provided by Requestor was received by the Claimant after the surgery. Therefore, since the surgery was not medically necessary, any durable medical equipment provided as a result of the surgery was also not medically necessary."

Response Submitted by: Downs ♦ Stanford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 30, 2015	L0180, L0120	$527.56	$490.18

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 §133.240 sets out guidelines for medical payments and denials.
3. 28 Texas Administrative Code §133.305 dispute of medical bills.
4. 28 Texas Administrative Code Part 1, Chapter 19, Subchapter U sets out the requirements for utilization

review of health care provided under Texas workers' compensation insurance coverage.

5. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 216 – Based on the findings of a review organization
   - W3 – Additional payment made on appeal/reconsideration
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time

Issues

1. Was the service in dispute retrospectively reviewed per Division guidelines?
2. Is the carrier's position statement supported?
3. Was the applicable notice filed to dispute of compensability?
4. Was the health care provider afforded a reasonable opportunity to discuss the billed health care?
5. What is the applicable rule pertaining to reimbursement?
6. Is the requestor entitled to additional reimbursement?

Findings

1. The services in dispute are L0180 – Cervical, multiple post collar, occipital/mandibular supports, adjustable and L0120 - Cervical, flexible, nonadjustable, prefabricated, off-the-shelf (foam collar) or specifically durable medical equipment. The carrier denied these services as, 216 – "Based on the findings of a review organization." 28 Texas Administrative Code Part 1, Chapter 19, Subchapter U sets out the requirements for utilization review of health care provided under Texas workers' compensation insurance coverage. Applicable 28 TAC §19.2003 (b)(31) defines retrospective review as "A form of utilization review for health care services that have been provided to an injured employee." No documentation was found to support that the insurance carrier retrospectively reviewed the reasonableness and medical necessity of the service in dispute (durable medical equipment) pursuant to the minimal requirements of Chapter 19, subchapter U. The insurance carrier failed to follow the appropriate administrative process and remedy in order to address its assertions regarding appropriateness of care and medical necessity for the specific services in dispute.
2. The respondent states in pertinent part, "The durable medical equipment provided by Requestor was received by the Claimant after the surgery. Therefore, since the surgery was not medically necessary, any durable medical equipment provided as a result of the surgery was also not medically necessary." 28 Texas Administrative Code §133.307(d)(I) states,

   > If the medical fee dispute involves medical necessity issues, the insurance carrier shall attach a copy of documentation that supports an adverse determination in accordance with §19.2005 of this title (relating to General Standards of Utilization Review).

   Review of the submitted documentation finds:

   - Peer Review from January 18, 2016 – "The surgery performed by Dr. Batlle on December 30, 2015, was for pre-existing multilevel degenerative disc disease of the cervical spine, not the compensable injury."

The Division finds insufficient evidence to support that the DMEPOS items in dispute received an adverse determination at the time a peer review dated, January 18, 2016, was performed which only discusses a surgery, not the DMEPOS in dispute. The respondent's position will not be considered in this review.

3. 28 Texas Administrative Code Rule §133.240(h) states,

   > An insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code §409.021, and §124.2 and §124.3 of this title (relating to Investigation of an Injury and Notice of Denial/Dispute) if the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that:
   > (1) the injury is not compensable;
   > (2) the insurance carrier is not liable for the injury due to lack of insurance coverage; or

(3) the condition for which the health care was provided was not related to the compensable injury.

Review of Division records finds that no PLN01 (Notice of Denial of Compensability/Liability) or PLN11 (Notice of Disputed Issue) has been filed by the respondent in relation to this matter. Therefore, the requirements of Rule §133.240 (h) were not met.

4. 28 Texas Administrative Code Rule §133.240 (q) states,

> 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.

28 Texas Administrative Rule §19.2010 Requirements Prior to Issuing Adverse Determination states,

> In any instance in which a URA is questioning the medical necessity or appropriateness of the health care services prior to issuance of an adverse determination, the URA must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the injured employee with a physician, dentist, or chiropractor. If the health care services in question are dental services, then a dentist may conduct the discussion if the services in question are within the scope of the dentist's license to practice dentistry. If the health care services in question are chiropractic services, then a chiropractor may conduct the discussion if the services in question are within the scope of the chiropractor's license to practice chiropractic. The discussion must include, at a minimum, the clinical basis for the URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision.
>
> (1) The URA must provide the URA's telephone number so the provider of record may contact the URA to discuss the pending adverse determination.
>
> (2) The URA must maintain, and submit to TDI or TDI-DWC on request, documentation that details the discussion opportunity provided to the provider of record, including the date and time the URA offered the opportunity to discuss the adverse determination, the date and time that the discussion, if any, took place, and the discussion outcome

The Division found no evidence to support the Universal DME LLC, was afforded the opportunity to discuss the health care services in dispute. Based on the above, the carrier's denial is not supported. The services in dispute will be reviewed per applicable rules and fee guidelines.

5. 28 Texas Administrative Code §134.203(d) states,

> The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:
>
> (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;
>
> (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or
>
> (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.

The services in dispute will be calculated as follows:

Date of Service	Submitted Code	Billed Amount	2015 14th Quarter Texas DMEPOS Fee Schedule	Maximum Allowable Reimbursement
December 30, 2015	L0180	$495.00	$368.39	$368.39 x 125% = $460.49
December 30, 2015	L0120	$32.56	$23.75	$23.75 x 125% = $29.69
			Total	$490.18

6. The maximum allowable reimbursement for the services in dispute is $490.18. The Carrier previously paid $0.00. The remaining balance of $490.18 is due to the requestor.

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 $490.18.

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 in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $490.18 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		May 12, 2016
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, 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.