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 Orthopedic and Spine Hospital

Respondent Name
General Motors

MFDR Tracking Number
M4-17-2035-01

Carrier's Austin Representative
Box 47

MFDR Date Received
March 3, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The services above were denied due to lack of preauthorization. The services were approved prior to being provided."

Amount in Dispute: $1,130.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent filed a PLN-11 on 1/28/16 disputing the injury of 1/9/16 included any condition or body part beyond a sprain/strain of the lumbar paravertebral musculature. Requestor's medical bill indicated they treated the Claimant for lumbar radiculopathy. Therefore, the denial for the medical bill based on extent of injury was appropriate."

Response submitted by: Downs Stanford PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 30, 2016	CPT 64483-LT	$1,130.60	$1,130.60

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 §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. 28 Texas Administrative Code §134.600 sets out the requirements of prior authorization
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Payment denied/reduce for absence of precertification/authorization

- W3 – Additional payment made on appeal/reconsideration
- P2 – Not a work related injury/illness and thus not the liability of the workers' compensation carrier
- 219 – Based on extent of injury
- 269 – This billing is for a service unrelated to the work illness or injury

Issues

1. Is the insurance carrier's denial reasons supported?
2. What rule is applicable to reimbursement?
3. Is additional reimbursement due?

Findings

1. The requestor is seeking reimbursement for outpatient hospital services rendered March 30, 2016. Review of the submitted documentation found,

    - Sedgwick notice of 03/25/2016 – Left L3-4, L405 TF ESI – Low back /Certified by peer reviewer reference number 1986777

    - National Medical Review Co notice of 03/25/2016, "is the request for Left L3-4, L4-5 TF ESI medically necessary? Yes. Assessment: Certified."

    The carrier's denial for lack of pre-auth is not supported and will not be considered in this review.

    At the time of reconsideration, the insurance carrier denied the services based on extent of injury.

    28 TAC 134.600 (l) states,

    > The insurance carrier shall not withdraw a preauthorization or concurrent utilization review approval once issued. The approval shall include:
    >
    > (3) a notice of any unresolved dispute regarding the denial of compensability or liability or an unresolved dispute of extent of or relatedness to the compensable injury; and

    Review of the submitted authorization from Sedgwick found no notice was given to the health care provider regarding the extent of injury.

    The reconsideration denial based on extent will not be considered in this review.

2. The applicable fee guideline is found in 28 TAC 134. f) 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 Outpatient Prospective Payment System (OPPS) 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) 200 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 130 percent.

    Review of the submitted medical bill found a request for implants was not applicable. The maximum allowable reimbursement based on the above is;

Date of service	CPT Code	Billed amount	Status Indicator	Medicare allowed	Adjusted APC rate	MAR (adj APC x 200)
March 30, 2016	64483	$2,219.00	T	$585.17	$570.14	$1,140.28

4. The total allowable reimbursement is $1,140.28. The requestor is seeking $1,130.60. 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 $1,130.60.

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 $1,130.60, 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 14, 2019

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..