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 and Address

TEXAS BACK INSTITUTE
PO BOX 262409
PLANO TX 75026-2409

Respondent Name
Liberty Mutual Fire Insurance

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-12-2300-01

MFDR Date Received
March 6, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Procedure is documented."

Amount in Dispute: $725.29

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT 22851 was not supported in the documentation."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 23, 2011	Professional Services	$725.29	$725.29

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 134.203 sets out guidelines for professional medical services.
3. 28 Texas Administrative Code 134.20 sets out medical bill submission requirements for health care providers.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - X901 – DOCUMENTATION DOES NOT SUPPORT LEVEL OF SERVICE BILLED.
   - X598 – CLAIM HAS BEEN RE-EVALUATED BASED ON ADDITIONAL DOCUMENTATION SUBMITTED; NO ADDITIONAL PAYMENT DUE.

Issues

1. Is the disputed services supported by documentation?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services with reason code X901 - DOCUMENTATION DOES NOT SUPPORT LEVEL OF SERVICE BILLED." The American Medical Association (AMA) CPT code description for 22851 is "Application of intervertebral biomechanical device(s) (eg. Synthetic cage(s), methylmethacrylate) to vertebral defect or interspace. Review of the Op Report found the following:
    - …"dispatched the robot to place pedicle screws into L3 and L4.
    - …"placed a short rod, contoured it slightly for lordosis and distracted across the disk space."
    - …"inserted the structural anterior lumbar interbody graft"
    - …"released the distraction on the right-hand side, placed a further rod on the left-hand side, added further lordosis into the construct, and then tightened after compressing down all the collars and nuts."

    Review of this submitted information finds procedure was identifiable and the Carrier's denial is not supported. Therefore, this service will be reviewed per applicable rules and fee guidelines.
2. The services in dispute are eligible for payment. Per 28 TAC§134.203(c)(1) the maximum allowable reimbursement (MAR) for the services in dispute is: (2011 DWC Conversion Factor / Medicare Conversion Factor) x Facility Price. (68.47 / 33.9764) x 405.33 = $816.83

    The total allowable for the services in dispute is $816.83. The requestor is seeking $725.29. 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 $725.29.

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 $725.29 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	January 23, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.