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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
DEL SOL MEDICAL CENTER

Respondent Name
AMERICAN ZURICH INSURANCE COMPANY

MFDR Tracking Number
M4-15-1548-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 27, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Authorization was requested at the time services were rendered but denied by adjuster at the time the request was made. BRC issue resolved and all services are compensable. Please review as authorization issue no needs to be resolved."

Amount in Dispute: $31,500.54

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This dispute was filed with the Division on January 27, 2015. . . . A provider must request medical dispute resolution on a fee issue or a retrospective medical necessity review within one year of the date of service. . . . If there is a pending compensability, extent of injury dispute, or liability dispute, that deadline is extended '60 days after the date the requestor receives the final decision, inclusive of all appeals . . . In this case, the extent of injury issue was resolved by benefit dispute agreement on December 18, 2013. . . . Requestor failed to file its request for medical dispute resolution within 60 days of December 18, 2013. Accordingly, the request was untimely and an order should be issued that MRD does not have jurisdiction to review this dispute."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 20, 2013 to July 25, 2013	Inpatient Hospital Services	$31,500.54	$20,654.86

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 §19.2009 sets out notice requirements for utilization review determinations.
2. 28 Texas Administrative Code §19.2010 sets out requirements prior to issuing adverse determinations.
3. 28 Texas Administrative Code §133.240 sets out provisions regarding medical payments and denials.
4. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
5. 28 Texas Administrative Code §134.404 sets out the acute care hospital fee guideline for inpatient services.
6. 28 Texas Administrative Code §134.600 sets out sets out rules regarding preauthorization of health care.
7. On August 25, 2015, the Division requested additional information from the parties pursuant to 28 Texas Administrative Code §133.307(f)(1), which states, "The division may request additional information from either party to review the medical fee issues in dispute. The additional information must be received by the division no later than 14 days after receipt of this request." The Division asked for information regarding the request for preauthorization and subsequent response and actions of the insurance carrier related to any such requests. Both the requestor and respondent submitted additional information in response to the Division's requests. These findings and decision are based on the information provided by both parties up to the time of review.
8. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - Based on extent of injury
   - 39 – Services denied at the time authorization/precertification was requested.
   - 219 – Based on extent of injury
   - 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME
   - 247 – A PAYMENT DENIAL HAS ALREADY BEEN RECOMMENDED FOR THIS SERVICE.
   - B13 – PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT.
   - 5388 – THIS IS A RECONSIDERATION OF A BILL PREVIOUSLY PROCESSED IN ANOTHER MEDICAL BILL REVIEW PLATFORM. PLEASE REFERENCE ABOVE #.
   - 6485 – At the adjuster's request, no allowance was made.
   - 6486 – Preauthorization required but not requested.

Issues

1. Are there unresolved issues of compensability, liability, or extent of injury regarding the disputed services?
2. Did the requestor timely submit the request for medical fee dispute resolution?
3. Does the respondent's position statement address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed?
4. Did the health care provider request preauthorization for the services in dispute?
5. What is the applicable rule for determining reimbursement of the disputed services?
6. What is the recommended payment for the services in dispute?
7. Is the requestor entitled to additional reimbursement?

Findings

1. The request for medical fee dispute resolution was received at the Division on January 27, 2015. The dates of service in dispute are from July 20, 2013 through July 25, 2013. The respondent contends that the request is untimely, stating:

   > In this case, the extent of injury issue was resolved by benefit dispute agreement on December 18, 2013. . . . Requestor failed to file its request for medical dispute resolution within 60 days of December 18, 2013. Accordingly, the request was untimely and an order should be issued that MRD does not have jurisdiction to review this dispute.

   Rule 133.307(c)(1) requires that:

   > A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by

the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.

(A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

(B) A request may be filed later than one year after the date(s) of service if:

(i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability

While the initial benefit review conference was held on December 18, 2013, this was not the date of the final decision. The rule allows the requestor to submit the request within 60 days after the date the requestor receives the final decision, inclusive of all appeals. Additional proceedings were held on January 15, 2015 concerning the same extent of injury dispute. Consequently, the timely filing deadline was extended 60 days from the date the health care provider received notice of the decision in those proceedings. The January 27, 2015 MFDR filing was within 60 days from that date. The Division concludes that this request for medical fee dispute resolution was timely received in accordance with the requirements of §133.307(c)(1)(B)(i).

2. The insurance carrier denied disputed services with claim adjustment reason code 219 – "Based on extent of injury." Review of the submitted information finds that the disputed issues of liability, compensability or extent of injury have been resolved prior to the filing of this medical fee dispute. This denial reason is not supported.

3. The respondent's position statement raises new denial reasons or defenses that were not listed on the insurance carrier's explanations of benefits. 28 Texas Administrative Code §133.307(d)(2)(F) requires that "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." No documentation was found to support that the respondent presented these new denial reasons to the requestor prior to the date that the request for medical dispute resolution was filed with the Division; therefore, the Division concludes that the respondent has waived the right to raise any such new denial reasons or defenses. Any newly raised denial reasons or defenses shall not be considered in this review.

4. The insurance carrier denied disputed services with reason code 6486 – "Preauthorization required but not requested." However, this denial reason is not supported. The submitted documentation supports by a preponderance of the evidence that the health care provider requested preauthorization by telephone in accordance with §134.600(f) which requires that the request "shall be sent to the insurance carrier by telephone, facsimile, or electronic transmission."

   Additionally, the insurance carrier denied each line item with reason code 39 – "Services denied **at the time authorization/precertification was requested**" [emphasis added] with additional comment "Based on extent of injury." (As stated above, the extent issues have since been resolved.) Based on the insurance carrier's EOB, the Division finds that the insurance carrier has conceded that authorization/precertification was requested.

   Moreover, 28 Texas Administrative Code §134.600(g)(3) requires that "If denying the request, the insurance carrier shall indicate whether it is issuing an adverse determination, and/or whether the denial is based on an unrelated injury or diagnosis in accordance with subsection (m) of this section." The denial reason on the explanation of benefits (EOB) indicates only that the denial was based on an unrelated injury or diagnosis; it does not indicate that an adverse determination was issued. The insurance carrier did not provide documentation that the services had been submitted to utilization review, that the services were prospectively reviewed for medical necessity or that an adverse decision had been issued.

   Subsection (j) further requires that:

   The insurance carrier shall send written notification of the approval of the request, adverse determination on the request, or denial of the request under subsection (g) of this section because of an unrelated injury or diagnosis within one working day of the decision to the:

   (1) injured employee;
   (2) injured employee's representative; and
   (3) requestor, if not previously sent by facsimile or electronic transmission.

While the insurance carrier concedes that a request was received, no documentation was presented to support the insurance carrier sent written notification of the adverse determination in accordance with subsection (j).

Nor does the submitted documentation support that the insurance carrier made any adverse determination in accordance with §134.600(a)(1), which requires "A determination by a utilization review agent made on behalf of a payor that the health care services provided or proposed to be provided to an injured employee are not medically necessary or appropriate."

No documentation was presented to support that the insurance carrier met the notice and reasonable opportunity requirements of §134.600(m), which requires that:

> In accordance with §19.2010 of this title (relating to Requirements Prior to Issuing Adverse Determination), the insurance carrier shall afford the requestor a reasonable opportunity to discuss the clinical basis for the adverse determination prior to issuing the adverse determination. The notice of adverse determination must comply with the requirements of §19.2009

While the documentation supports that the health care provider requested preauthorization, because the health care provider did not actually obtain preauthorization for the disputed services—but still provided the disputed services anyway—the services were then still subject to retrospective medical necessity review at the time of bill processing. However, the insurance carrier did not avail itself of the opportunity to perform a retrospective medical necessity review of the disputed services during the bill review process, and did not issue a denial based on such a review.

Per 28 Texas Administrative Code §133.240(p):

> all utilization review must be performed by an insurance carrier that is registered with or a utilization review agent that is certified by the Texas Department of Insurance to perform utilization review in accordance with Insurance Code, Chapter 4201 and Chapter 19 of this title.

Additionally, subsection §133.240(q) requires that:

> 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

No documentation was presented to support that the insurance carrier met the requirements of §133.240(p) or (q) during the bill review process. The respondent has therefore waived the right to raise any issues regarding the medical necessity of the disputed services.

For the above reasons, the Division concludes that the insurance carrier's denial reasons based on authorization/precertification are not supported. The medical fee issues will therefore be reviewed per applicable Division rules and fee guidelines.

5. This dispute relates to facility medical services provided in an inpatient acute care hospital with reimbursement 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.

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

6. Per §134.404(f)(1)(A), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment by 143%. 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 470. The services were provided at Del Sol Medical Center, El Paso, Texas. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $14,443.96. This amount multiplied by 143% results in a MAR of $20,654.86.
7. The maximum allowable reimbursement for the services in dispute is $20,654.86. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $20,654.86. 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 $20,654.86.

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 $20,654.86, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	October 16, 2015
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.