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
STEPHEN COURTNEY MD

Respondent Name
American Home Assurance Company

MFDR Tracking Number
M4-06-0777-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 20, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "IW prevailed at BRC (documents attached)."

Amount in Dispute: $74,347.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "All reductions of the disputed charges were appropriately made. Further, the documentation provided does not establish medical necessity."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 27, 2004	20936, 20936, 20937, 20937, 22558, 22558, 22612, 22612, 22630, 22630, 22842, 22842, 22851, 22851, 22851, 22851, 62319, 63042, 63042, 63044, 63044, 63090, 63090, 63091, 63091, 76000	$74,347.00	$0.00

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. Former 28 Texas Administrative Code §134.600 sets out procedure for Preauthorization, Concurrent Review, and Voluntary Certification of Health Care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 1 – Preauthorization not obtained.
   - 4 – The charge exceeds the scheduled allowance for multiple procedures.
   - 2 – The charge for this procedure exceeds the fee scheduled or usual and customary allowance.
   - E 1 – This workers compensation claim has been denied.

Issues

1. Did the insurance carrier submit documentation to support the denial of "E 1-– This workers compensation claim has been denied?
2. Did the requestor obtain preauthorization for the principal scheduled procedure rendered on October 27, 2004?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor submitted documentation to support that the extent of injury issue was resolved by submitting a copy of the BRC agreement with the dispute. The insurance carrier did not raise the extent of injury issue in the position statement. The Division finds that there is no dispute as to extent of injury. The carrier's denial reason is not supported. The services will therefore be reviewed per applicable Division rules and statutes.
2. Per 28 Texas Administrative Code §134.600 "(h) The non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions including the principal scheduled procedure(s) and the length of stay."

   Review of a preauthorization letter issued by Aetna Life Insurance Company, dated October 20, 2004 indicates that the surgical procedure was preauthorized from 10/27/2004-10/31/2004 5 day(s) surgical coverage. The preauthorization letter was issued by the private health insurer. No documentation was submitted by the requestor to support that preauthorization was obtained from the workers compensation carrier. As a result, preauthorization was required and not obtained. Therefore, reimbursement for the disputed surgical services cannot be recommended.
3. Review of the submitted documentation finds that the requestor is not entitled to reimbursement for disputed date of service October 27, 2004.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		April 3, 2014
Signature	Medical Fee Dispute Resolution Officer	Date
	Martha Luévano	April 3, 2014
Signature	Medical Fee Dispute Resolution Manager	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.