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 ORTHOPEDIC HOSPITAL
8101 W SAM HOUSTON PKWY S
HOUSTON TX 77072-5077

Respondent Name
AMERICAN HOME ASSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-10-0140-01

MFDR Date Received
September 8, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We regret prior authorization was not obtained but ask that you reconsider our claim for payment."

Amount in Dispute: $13,564.84

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier denied the provider's medical bill because it did not obtain preauthorization. . . . In addition to the provider failing to obtain preauthorization for the surgical procedure, it also provided services for a non-compensable abnormality."

Response Submitted by: Flahive, Ogden & Latson, 504 Lavaca, Suite 1000, Austin, Texas 78701

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 7, 2008	Outpatient Hospital Services	$13,564.84	$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 medical fee disputes.
2. 28 Texas Administrative Code §133.2 defines words and terms related to medical billing and processing.
3. 28 Texas Administrative Code §134.600 sets out guidelines for preauthorization of health care.
4. A contested case hearing was held on October 1, 2009 to decide issues related to compensability and disability for the disputed injury. The Division found that the injured employee sustained a compensable injury on July 29, 2008, extending to include lumbar spondylolisthesis at L5-S1, but not to include spinal stenosis at C4-5 and C5-6 or diskitis at L3-4. The Division ordered the insurance carrier to pay benefits in accordance with the decision.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 219 – Lack of proof preauthorization.

Issues

1. Did the respondent's position statement raise new denial reasons or defenses?
2. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code §133.307(d)(2)(B) states that "The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR [medical dispute resolution] was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." The respondent's position statement asserts that "In addition to the provider failing to obtain preauthorization for the surgical procedure, it also provided services for a non-compensable abnormality." As stated above, as the result of a contested case hearing, the Division has found that the injured employee sustained a compensable injury, extending to include lumbar spondylolisthesis at L5-S1, but not to include spinal stenosis at C4-5 and C5-6 or diskitis at L3-4. The Division ordered the insurance carrier to pay benefits in accordance with the decision. There are no unresolved issues related to compensability for the disputed injury. Review of the submitted explanations of benefits finds that the insurance carrier did not deny the services for reasons related to compensability or extent of injury. No documentation was submitted to support that these newly raised denial reasons or defenses were ever presented to the requestor prior to the date the request for MDR was filed. Therefore, these newly raised defenses or denial reasons shall not be considered in this review.
2. The insurance carrier denied payment for the disputed services with reason code 219 – "Lack of proof preauthorization." Per 28 Texas Administrative Code §134.600(c) "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions); (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care." §134.600(p)(1) states that the non-emergency health care requiring preauthorization includes "inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay." 28 Texas Administrative Code §133.2(3)(A) defines a medical emergency as "the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part." Review of the submitted medical records finds insufficient documentation to support a medical emergency. No documentation was found to support that preauthorization was approved prior to providing the health care. The insurance carrier's denial reason is supported. Reimbursement is not recommended.

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

	Grayson Richardson	February 11, 2014
Signature	Medical Fee Dispute Resolution Officer	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.