



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 and Address

SHANNON MEDICAL CENTER

Respondent Name

NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number

M4-11-4714

Carrier's Austin Representative

Box Number 19

MFDR Date Received

August 12, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by SHANNON MEDICAL CENTER to audit their Workers Compensation claims. We have found in this audit you have not paid what we determine as a amount for these outpatient services. It was a PRE AUTH on file for date of service."

Amount in Dispute: \$612.82

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on August 16, 2011 and September 22, 2011. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Table with 4 columns: Date(s) of Service, Disputed Service(s), Amount In Dispute, Amount Due. Row 1: March 5, 2010, 72146-TC, \$612.82, \$0.00

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 §133.305 sets out the general Medical Dispute Resolution guidelines.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedure for Medical Dispute Resolution of Medical Necessity Disputes.

## Issues

1. What are the denial reason(s) raised by the insurance carrier during the bill review process?
2. Did the medical fee dispute referenced above contain information/documentation that indicates that there are **unresolved** issues of medical necessity?
3. Are the disputed services eligible for review by Medical Fee Dispute Resolution?
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 216 – Based on the findings of a review organization

## Findings

1. The medical fee dispute referenced above contains information/documentation that indicates that there are **unresolved** issues of medical necessity for the same service(s) for which there is a medical fee dispute. Review of the EOBs presented by the both the requestor and respondent indicate denial reason code “216 – Based on the findings of a review organization.” The requestor indicates that the disputed services were preauthorized. Review of box 63 on the UB-04 documents “REASONABLE & NEC” no preauthorization reference number was included in box 63. Review of the documentation submitted with the DWC060 does not contain a preauthorization letter issued by the insurance carrier. As a result, the Division finds that the requestor submitted insufficient documentation to support that the disputed services were preauthorized. As a result, due to the denial of medical necessity, the requestor may seek resolution by requesting an IRO for medical necessity determination, pursuant to 28 Texas Administrative Code §133.308.
2. Review of the submitted documentation finds that the medical dispute referenced above contains information/documentation that indicates that there are **unresolved** issues of medical necessity for the same service(s) for which there is a medical fee dispute.
3. The Division hereby notifies the requestor the appropriate process for resolution of an unresolved issue of medical necessity requires filing for an independent review to be conducted by an IRO (independent review organization) appropriately licensed by the Texas Department of Insurance, pursuant to 28 Texas Administrative Code §133.308. Information applicable to HEALTH CARE PROVIDERS on how to file for an IRO may be found at [http://www.tdi.texas.gov/hmo/iro\\_requests.html](http://www.tdi.texas.gov/hmo/iro_requests.html) under **Health Care Providers or their authorized representatives**.

28 Texas Administrative Code §133.305(b) requires that “If a dispute regarding...medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding...medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021.

The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals.

The division finds that due to the unresolved medical necessity issues, the medical fee dispute request is not eligible for review until a final decision has been issued in accordance with 28 Texas Administrative Code §133.308.

**Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. This dismissal is based upon a review of all the evidence presented by the parties in this dispute. Even though not all the evidence was discussed, it was considered. The Division finds that this dispute is not eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307.

**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 dispute is not eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
Date

May 6, 2016

***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 MFDR 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 this *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.**