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

ALEGIS REVIEW GROUP LLC
1201 LAKE WOODLANDS DRIVE STE 4024
THE WOODLANDS TX 77380

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-13-1311-01

MFDR Date Received
JANUARY 25, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "[Injured worker's] admission was not emergent, nor were his procedures. However, they were medically necessary because they could have progress to sepsis and loss of his lower limb. Based on this facts, I would request that you re-review this case and consider payment on the date listed above."

Amount in Dispute: $31,344.08

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual maintains its position that the admission to the hospital was not an emergency and did not require emergency procedures. The legal nurse consultant for the requestor stated in her letter of 9/14/12 that that '…[injured worker's] admission was not emergent, nor were his procedure.'… She goes on to say the treatment was medically necessary. However, Texas Mutual did not deny reimbursement on the basis of no medical necessity but on an administrative failure to seek and obtain prior authorization of the admission."

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 24, 2012 through April 16, 2012	Inpatient Hospital Services	$31,344.08	$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 §134.600 sets out the procedures for obtaining preauthorization.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Precertification/authorization/notification absent.
   - 206 – National provider identifier – missing.

- F03 – A Medicare number is required to calculate the CMS inpatient reimbursement.
- 930 – Pre-authorization required. Reimbursement denied.

Issues

1. Was the requestor required to obtain preauthorization for the services in dispute?
2. Is the requestor entitled to reimbursement?

Findings

1. According to the requestor, the hospital admission for the injured worker "was not emergent, nor were his procedures." In accordance with 28 Texas Administrative Code §134.600(p)(1) non-emergency health care requiring preauthorization includes inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay.
2. Review of the submitted documentation finds that the requestor did not obtain preauthorization for the in-patient hospitalization. Therefore, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that 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

Signature	Medical Fee Dispute Resolution Officer	February 20, 2014 Date
Signature	Medical Fee Dispute Resolution Manager	February 20, 2014 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, effective May 31, 2012, *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 MDR 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.