



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION GENERAL INFORMATION

Requestor Name

VICTORY MEDICAL CENTER HOUSTON

Respondent Name

FEDEX GROUND PACKAGE SYSTEM

MFDR Tracking Number

M4-13-2243-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

May 3, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The authorization was clearly given for medical necessity, which I am not disputing. I am disputing the fact that for some unknown reason, an authorization was given for a patient to have an out-patient procedure that is clearly an in-patient procedure. .. It is our opinion that our total reimbursement for both the services and the implants should be \$18,295.75."

Amount in Dispute: \$18,295.75

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is our position that no additional reimbursement is due as the above mentioned dates of service exceed the outpatient preauthorization. In addition a retro review was done that was non certified."

Response Submitted by: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 14, 2012 through August 17, 2012	DRG 470 @ 108%	\$12,245.75	\$0.00
August 14, 2012	Revenue Code 0278 - Implants	\$6,050.00	\$0.00
		\$18,295.75	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.1 sets forth general provisions related to medical reimbursement.
- 28 Texas Administrative Code §134.404 sets out the Inpatient Hospital Facility Fee Guideline.
- Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 197 – Preauthorization/authorization /notification absent.

Issues

- Did the requestor obtain preauthorization for the inpatient facility services?
- Is the requestor entitled to additional reimbursement?

Findings

- 1. The requestor seeks reimbursement for inpatient facility charges rendered on August 14, 2012 through August 17, 2012 and implants charges rendered on August 14, 2012. The Requestor billed the Respondent \$73,751.52 received payment from the Respondent in the amount of \$0.00, and is requesting payment in the amount of \$18,295.75. The Requestor seeks reimbursement under 28 Texas Administrative Code §134.404.

The insurance carrier denied/reduced the disputed services with denial reason(s) code(s), "197 – Preauthorization/ authorization /notification absent."

Per 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."

Review of the submitted documentation does not support that disputed services were preauthorized as inpatient services. The requestor submitted a copy of a preauthorization letter to support that the services were preauthorized as an outpatient hospital services. As a result, the requestor is not entitled to reimbursement for these disputed services.

- 2. The requestor did not support that the disputed services were preauthorized as required under Per 28 Texas Administrative Code §134.600 (p) (1). Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment for the disputed services is due. As a result, reimbursement is not recommended for the disputed charges.

Conclusion

For the reasons stated above, the Division finds that the requestor has failed to establish 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 services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 29, 2016 Date
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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.