



**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](http://www.tdi.texas.gov)

**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

**GENERAL INFORMATION**

**Requestor Name**

Pine Creek Medical Center

**Respondent Name**

Amerisure Mutual Insurance Co

**MFDR Tracking Number**

M4-13-2395-01

**Carrier's Austin Representative**

Box Number 47

**MFDR Date Received**

May 20, 2013

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Rule 134.403, the Medicare facility Specific reimbursement amount is multiplied by 200%"

**Amount in Dispute:** \$2,031.05

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "CPT code 29895 has no preauthorization."

**Response Submitted by:** Amerisure

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 2, 2012	29895	\$2,031.05	\$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 §134.600 sets out the procedures for preauthorization, concurrent utilization review, and voluntary certification of health care.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
  - W1 – Workers compensation state fee schedule adjustment
  - 197 – Payment denied/reduced for absence of precertification/preauthorization
  - 193 – Original payment decision is being maintained
  - 18 – Duplicate charge

**Issues**

- Was the service in dispute subject to prior authorization?
- Is the requestor entitled to reimbursement?

**Findings**

1. The carrier denied the service as, 197 – “Payment denied/reduced for absence of precertification/preauthorization. 28 Texas Labor Code §134.600 states in pertinent part, (f) The requestor or injured employee shall request and obtain preauthorization from the insurance carrier prior to providing or receiving health care listed in subsection (p) of this section..., ... (p) Non-emergency health care requiring preauthorization includes:
  - (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay;
  - (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;
 Review of the submitted documentation finds that procedure 29895 was not requested and therefore the carrier’s denial is supported.
2. Requirement for prior authorization not met, no additional reimbursement 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**

Signature	Medical Fee Dispute Resolution Officer	April 14, 2014 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.**