



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

South Texas Health System

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-13-2400-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

May 20, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per Rule 134.600 section P, clinic and treatment rooms do not require authorization. Furthermore we were told by the carrier that this patient is covered for life for wound care for this wound."

Amount in Dispute: \$1,079.21

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor provided hospital outpatient wound care to the claimant on the dates listed above then billed Texas Mutual for this. Upon receipt of the billing Texas Mutual reviewed the billing, the attach documentation, reviewed the claim file for preauthorization, and finding none Texas Mutual denied payment consistent with Rule 134.600(p)(2)."

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 3 – 31, 2012	Outpatient Hospital Services	\$1,079.21	\$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 preauthorization, concurrent utilization review, and voluntary certification of health care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 197 – Payment denied/reduced for absence of precertification/preauthorization.
 - 785 – Service rendered is integral to service requiring preauthorization. Preauthorization not sought/approval not obtained for that service.
 - 930 – Pre-authorization required, reimbursement denied.
 - 878 – Appeal (request for reconsideration) previously processed.

- 18 – Duplicate claim/service.

Issues

1. Was the service in dispute subject to prior authorization?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the service as, 197 – “Precertification/authorization/notification absent. 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 the bill type of disputed services is, “131 - (Hospital, Outpatient, Admit thru Discharge Claim)”. Contrary to requestor’s statement this type of service does require prior authorization. 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

Date

April 14, 2014

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.