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
MMC SAN AUGUSTINE

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-13-2668-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
JUNE 17, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached billing was denied based upon a lack of preauthorization. Under normal circumstances the utilization review process establishes the medical necessity of a treatment before the service is rendered. As these services were not subjected to a prior medical necessity review, we ask that you evaluate the treatment in question pursuant to 28 Tex. Admin. Code §19.2015 (Regarding 'Utilization Review for Healthcare Provided Under Workers' Compensation Insurance Coverage') This section specifically allows for 'Retrospective Review of Medical Necessity,' and requires carriers to perform 'such retrospective review … under the direction of a physician.' We have every confidence that the services referenced herein were reasonable and medically necessary."

Amount in Dispute: $16,497.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual Insurance Company received a TWCC-60 from the above-mentioned requester. Pursuant to Commission Rule 133.307(d) Texas Mutual files the attached, completed response, and related items. Texas Mutual requires additional time to respond given the status of the requestor as a critical access hospital."

Response Submitted by: TEXAS MUTUAL INSURANCE CO.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 10, 2012 through October 13, 2012	Inpatient Hospital Services	$16,497.30	$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. 28 Texas Administrative Code §133.10 sets out the procedures for required billing forms/formats.
4. 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.
- 240 – Preauthorization not obtained.

Issues

1. Is the requestor's NPI and Medicare numbers missing from the UB-04?
2. Did the requestor obtain preauthorization for an inpatient hospital admission?
3. Is the requestor entitled to reimbursement?

Findings

1. In accordance with 28 Texas Administrative Code §133.10(f)(2)(BB) the billing provider NPI number (UB-04/field 56) is required when the billing provider is eligible to receive an NPI number. According to the Division rule, the Medicare number is not listed as one of identifiers required on the medical bill. Review of the UB-04, Box 56 lists the NPI number of the health care provider; therefore, the respondent has not supported their denial of "206 – National Provider Identifier – missing and "F03 – A Medicare number is required to calculate the CMS inpatient reimbursement."
2. In accordance with 28 Texas Labor Code §134.600(p), non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay. Review of the documentation submitted by the requestor finds no convincing evidence to support preauthorization was obtained.
3. Preauthorization was not obtained for the inpatient stay; therefore, reimbursement is not 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	June 6, 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.