



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

TEXAS HEALTH OF DALLAS PRESBYTERIAN
3255 W PIONEER PARKWAY
ARLINGTON TX 76013

Respondent Name

Liberty Insurance Corp

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-13-3443-01

MFDR Date Received

August 27, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have found in this audit they have not paid what we determine to be the correct amount for this inpatient surgery per the Texas fee schedule in effect as of 2008."

Amount in Dispute: \$22.48

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The non authorized fourth inpatient day denial resulted in a reduction of the DRG payment."

Response Submitted by: Liberty Insurance Corp

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 20 – 24, 2012	Inpatient Hospital Surgical Services	\$22.48	\$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 a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - Z710 – The charge for this procedure exceeds the fee schedule allowance.
 - B406 – Documentation not submitted or insufficient to accurately review this bill
 - W3 – Additional payment made on appeal/reconsideration

- X170 – Pre-authorization was required, but not requested for this service per DWC Rule 134.600.

Issues

1. Did the respondent support their denial/reduction in payment?
2. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code §134.600 (p) states in pertinent part, “(p) Non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay.” The insurance carrier denied the service in dispute as X170 – “Pre-authorization was required, but not requested for this service per DWC Rule 134.600.” Review of prior authorization dated July 12, 2012 specifically states, “3 Day(s)”. Therefore, the carrier’s denial is supported.
2. Based upon the documentation submitted, no additional reimbursement is recommended.

Conclusion

For the reasons stated above, the division finds that no additional reimbursement is due.

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

_____	_____	March 17, 2014
Signature	Medical Fee Dispute Resolution Officer	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.