



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

Chang Neurosurgery & Spine Care

Respondent Name

Liberty Mutual Insurance Co

MFDR Tracking Number

M4-14-0179-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

September 18, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The patient had not met MMI, therefore payment for surgical intervention should not be denied."

Amount in Dispute: \$24,114.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Liberty Mutual believes that Change Neurosurgery Spine Care and Medical Center of Plano have been appropriately denied for services rendered to (claimant) for the 12/19/2012 date(s) of service."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 20, 2012	63051, 63710, 20931	\$24,114.00	\$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 guidelines for prospective and concurrent review of health care.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - X388 – Pre-authorization was requested but denied for this service per DWC Rule 134.600
 - 193 – Original payment decision is being maintained.

Issues

- Did the carrier support denial of the disputed services?
- Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed charges as, 197 – “Pre-authorization was requested but denied for this service...” 28 Texas Labor Code §134.600 states in pertinent part, “(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions); (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care; (C) concurrent utilization review of any health care listed in subsection (q) of this section that was approved prior to providing the health care; or (D) when ordered by the commissioner;” Review of the submitted documentation found;
 - a. Prior authorization request was denied.
 - b. Definition of emergency not met

The carrier’s denial is supported.

2. No additional payment can be recommended as provisions of Rule 134.600 not met.

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
		<u>July 10, 2014</u>

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.