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
MHHS Hermann Hospital

Respondent Name
Liberty Mutual Insurance

MFDR Tracking Number
M4-14-2714-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
May 5, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to the Hospital's records, the compensable body part is the right arm. The Hospital requested authorization for the surgery provided to the right arm upon the patient's admission, but that request was denied. The Hospital's bill was subsequently denied for lack of preauthorization. The Hospital provided medically necessary services to the patient, that are not only related to his work injury, but also to the same body part. Therefore, the Hospital should be paid in accordance with the Texas Department of Insurance's fee guidelines, and payment is warranted. "

Amount in Dispute: $68,867.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider sought pre-authorization on this non emergency admission as required, however, the pre-authorization was not granted and the provider made the decision to treat the employee knowing that pre-authorization was not obtained."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 15 -17, 2013	Outpatient Hospital Services	$68,867.50	$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 guidelines for prospective and concurrent review of health care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 388 – Pre-authorization was requested but denied for this service per DWC Rule 134.600
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Did the requestor support services are eligible for payment?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the services in dispute as, 388 – "Pre-authorization was requested but denied for this service per DWC Rule 134.600." Per 28 Texas Administrative Code §134.600 (p) states in pertinent part, "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;" The carrier's denial is supported.
2. Requirements of Rule 134.600 (p) not met no additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has 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

		February 11, 2015
Signature	Medical Fee Dispute Resolution Officer	Date
		February 11, 2015
Signature	Medical Fee Dispute Resolution Manager	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.