



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

Texas Health Denton

Respondent Name

Texas Mutual Insurance

MFDR Tracking Number

M4-14-3312-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

July 3, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Texas Mutual denied this bill for timely filing. This was billed to Medicare originally. Medicare denied this bill as possibly work related. We didn't receive the workman's compensation insurance information until 10/7/13. It was billed to Texas Mutual on 10/16/13. The hospital notes are attached for verification and the Medicare denial. We couldn't get a pre-auth from Texas Mutual since we weren't told about them until after the patient was discharged."

Amount in Dispute: \$1,480.84

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The claimant was admitted as an outpatient for a myelogram. The admission required preauthorization from Texas Mutual. It was not obtained. No payment is due."

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 1, 2013	Outpatient Hospital Services	\$1,480.84	\$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 healthcare.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 197 – Precertification/authorization/notification absent
 - 18 – Exact duplicate claim/service

Issues

1. Is the carrier liable for medical costs?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as, 197 –“Precertification/authorization/notification absent.” 28 Texas Labor Code §134.600 (p) states in pertinent part, “Non-emergency health care requiring preauthorization includes: (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section; and (c) states, “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 finds none of the situations described above occurred no was prior authorization obtained. Therefore, 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 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	February , 2015 Date
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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.