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
John Thomas MD

Respondent Name
Fort worth ISD

MFDR Tracking Number
M4-15-1096-01

Carrier's Austin Representative
Box Number 16

MFDR Date Received
December 9, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The work comp carrier – Tristar – denied our DME bill. We never received a paper or electronic remit from the work comp carrier."

Amount in Dispute: $675.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon review, it was determined that at the time of service pre authorization was not on file and therefore we stand on our denial as such."

Response Submitted by: Injury Management Organization

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 18, 2014	L1832	$675.00	$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

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. No explanation of benefits provided by either requestor or respondent.

Issues

1. Did the requestor support that services should be paid?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor provided a "Patient Note for (claimant)" dated Tuesday, September 16, 2014, that states, "left

message for WC to call me or send a denial due to no auth. They will not retro…" The respondent states, "Upon review, it was determined that at the time of service pre authorization was not on file and therefore we stand on denial as such." 28 Texas Labor Code §134.600 (p) states in pertinent part, "Non-emergency health care requiring preauthorization includes: (9) all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental);" Review of the submitted medical documentation finds;

a. Submitted medical claim contains code L1832 with price of $675.00
b. Statements from requestor and respondent indicate this claim was denied for lack of prior authorization.

As the billed charge for the service in dispute exceeded $500 prior authorization should have been obtained. Therefore, the respondent's position is supported.

2. 28 Texas Administrative Code §134.600 (c) states in pertinent part, "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;

As requirements of subsection (p)(9) were not met nor was this an "emergency" 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	Peggy Miller Medical Fee Dispute Resolution Officer	April , 2015 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.