



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

Houston Orthopedic Surgical Hospital

**Respondent Name**

New Hampshire Insurance Co

**MFDR Tracking Number**

M4-15-1173-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

December 15, 2014

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "These labs are mandatory and are taken place before surgery can be done."

**Amount in Dispute:** \$913.08

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Our bill audit company has determined no further payment is due."

**Response Submitted by:** Gallagher Bassett

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 21, 2014	36415, 80053, 84443, 85025, 93005	\$913.08	\$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 services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 197 – Precertification/authorization/notification absent
  - 193 – Original payment decision is being maintained

**Issues**

1. Did the requestor support prior authorization was obtained?
2. Is the requestor entitled to reimbursement?

**Findings**

1. The Carrier denied the disputed services as, "197 – Precertification/authorization/notification absent." 28

Texas Administrative Code §134.600 (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; and (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;" Review of the submitted medical claim finds

a. Type of bill indicated in box 4 is "131" or Hospital Outpatient.

Based on the submitted bill type, the Carrier's denial is supported.

2. Provisions of Rule 134.600 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

\_\_\_\_\_  
April 23, 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.**