



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

UMC at Brackenridge

Respondent Name

Texas Mutual Insurance

MFDR Tracking Number

M4-15-1184-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

December 15, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Under normal circumstances the utilization review process established the medical necessity of a treatment before the service is rendered. As these services were not subjected to a prior medical necessity review, we ask that you evaluate the treatment in question pursuant to 28 Tex. Admin. Code 19.2015...."

Amount in Dispute: \$3,087.71

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Absent preauthorization no payment is due."

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 2, 2014	Outpatient Hospital Services	\$3,087.71	\$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 services.
- 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. What is the applicable rule pertaining to prior authorization?
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) 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; (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 documentation found nothing to support that an exception to prior authorization requirements of Rule 134.600 were met. 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

		April 23, 2015
Signature	Medical Fee Dispute Resolution Officer	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.