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
Houston Orthopedic Surgical Hospital

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-15-2148-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 16, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We followed the proper protocol in this patients care by obtaining authorization."

Amount in Dispute: $1,005.61

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual declined to issue payment of the testing on the following basis: services (testing) provided that are integral to a service requiring preauthorization (elbow surgery) that was not preauthorized are also not authorized."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 10, 2014	Outpatient Hospital Services	$1,005.61	$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 healthcare.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Preauthorization/authorization/notification absent
   - 193 – Original payment decision is being maintained

Issues

1. Did the requestor support request for retrospective review?
2. Is the requestor entitled to reimbursement?

Findings

1. The disputed services were denied for as, "193 – Preauthorization/authorization/notificationabsent." 28 Texas Administrative Code §134.600(p) states, "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 in box 4 of UB-04 CMS-1500 "131" Outpatient Hospital
2. 28 Texas Administrative Code §134.600 (7) states, "Outpatient surgical services: surgical services provided in a freestanding surgical center or a hospital outpatient department to patients who do not require overnight hospital care." Documentation submitted supports disputed services were performed in an outpatient hospital setting and therefore required prior authorization. The carrier's denial is supported.

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 , 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.