TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Hermann Hospital

Respondent Name
Lumbermens Underwriting Alliance

MFDR Tracking Number
M4-15-2905-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 7, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to the Hospital's records, the patient was treated on the above dates of service for conditions arising from his work related injury. The patient required urgent treatment immediately upon his admission to the Hospital."

Amount in Dispute: $121,810.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on May 15, 2015. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 12-16, 2014	Inpatient Hospital Stay with Surgery	$121,810.04	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 §133.2 provides definitions for medical billing and processing.
3. 28 Texas Administrative Code §134.600 sets out the requirements for preauthorization of services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Payment adjusted for absence of precert/preauth
   - 193 – Original payment decision maintained

Issues

1. Did the disputed services require preauthorization?
2. Did the requestor obtain preauthorization?

Findings

1. The disputed services involve an inpatient hospital stay with surgery. The insurance carrier denied disputed services with claim adjustment reason code "197 – Payment adjusted for absence of precert/preauth." 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." In addition, 28 Texas Administrative Code §134.600 (c) states, in pertinent part that "The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care…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)."

   That is, unless the health care provider asserts that the services were performed as emergency services, then preauthorization is required. Submitted documentation does not support that the requestor asserted that the services were performed as an emergency. Therefore, the Division finds that the disputed services required preauthorization.

2. Review of the submitted information does not support that the requestor obtained the required preauthorization for the disputed services. Therefore, additional reimbursement cannot 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

		August 3, 2015
Signature	Medical Fee Dispute Resolution Officer	Date
		August 3, 2015
Signature	Director of Health Care Business Management	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, 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 MFDR 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.