



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

R&D Medical dba Wichita Medical

Respondent Name

City of Wichita Falls

MFDR Tracking Number

M4-15-3887-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

July 30, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: \$740.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Starr Comprehensive Solutions maintains the position that preauthorization was required for the above referenced codes and dates of service."

Response Submitted by: Starr Comprehensive Solutions, Inc. P.O. Box 801464, Houston, TX 77280

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 13, 2015 through June 13, 2015	E0910, K0004	\$740.00	\$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

- 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.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 197 – Payment denied/reduced for absence of precertification/authorization.
 - 181 – Procedure code was invalid on the date of service

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 197 – "Payment denied/reduce for absence of precertification/authorization." 28 Texas Administrative Code §134.600 (p)(9) requires that "all durable medical equipment (DME) in excess of \$500 billed charges per item (either purchase or expected cumulative rental);"

Review of the submitted information finds that cumulative rental for the services in dispute to be calculated as follows;

- Date of service March 13, 2015 - Trapeze bar rental amount \$40, January, 2013 through March, 2015 or 14 months = \$560.00
- Date of service April 13, 2015 - Trapeze bar rental amount \$40, January, 2013 through April, 2015 or 15 months = \$600.00
- Date of service May 13, 2015 - Trapeze bar rental amount \$40, January, 2013 through May, 2015 or 16 months = \$640.00
- Date of service June 13, 2015 - Trapeze bar rental amount \$40, January, 2013 through June, 2015 or 17 months = \$680.00
- Date of service March 13, 2015 – Lightweight wheelchair rental \$145.00, January, 2013 through March, 2015 or 14 months = \$2,030.00
- Date of service April 13, 2015 – Lightweight wheelchair rental \$145.00, January, 2013 through April, 2015 or 15 months = \$2,175.00
- Date of service May 13, 2015 – Lightweight wheelchair rental \$145.00, January, 2013 through May, 2015 or 16 months = \$2,320.00
- Date of service June 13, 2015 – Lightweight wheelchair rental \$145.00, January, 2013 through June, 2015 or 17 months = \$2,465.00

As the cumulative rental totals for the services in dispute exceeds \$500, prior authorization was required. The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

2. The Division found insufficient evidence to support the requirements of Rule 134.600 (p)(9) was met. Therefore no additional reimbursement is recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. After thorough review and consideration of the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The requestor has failed to establish 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

October , 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, 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.