



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

DOCTORS HOSPITAL AT RENAISSANCE

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-16-0175-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

September 21, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Doctors Hospital at Renaissance is kindly requesting that the above claim be reviewed for payment. Based on you denial for no authorization and network contract. It is of no fault from our facility that no authorization was obtained. The authorization request was called in on December 12, 2014 and was per Alvino at Texas Mutual no pre authorization is required for office visit. It is an unfair practice to penalize our facility for information that was withheld during the benefit verification."

Amount in Dispute: \$192.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 12/15/2014. The requestor billed an outpatient procedure for a minor surgical procedure according to its DWC60 documentation. Texas Mutual reviewed its claim file and found no request for preauthorization or approval of such. No payment is due absent preauthorization."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 15, 2014	Outpatient Hospital Service	\$192.00	\$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

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 preauthorization, concurrent utilization review and voluntary certification of health care.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - CAC-P12 – Workers’ Compensation Jurisdictional fee schedule adjustment
 - CAC-197 – Precertification/authorization/notification absent
 - 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
 - 930 – Pre-authorization required, reimbursement denied

Issues

1. Did the requestor obtain preauthorization for the disputed service?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code CAC-P12 – “Workers’ Compensation Jurisdictional fee schedule adjustment”, CAC-197 – “Precertification/authorization/notification absent”, 618 – “The value of this procedure is packaged into the payment of other services performed on the same date of service” and 930 – “Pre-authorization required, reimbursement denied.”

28 Texas Administrative Code §134.600(p) states “Non-emergency health care requiring preauthorization includes: (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section.”

Review of the submitted documentation provided by the requestor finds the disputed services did not obtain preauthorization for the outpatient hospital service on December 15, 2014 in with 28 Texas Administrative Code §134.600(p).

Therefore, no additional reimbursement is 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	10/9/15 Date
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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.