



# 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**

CENTRAL PARK SURGERY CENTER

**MFDR Tracking Number**

M4-16-2985-01

**MFDR Date Received**

May 27, 2016

**Respondent Name**

TX PUBLIC SCHOOL WC PROJECT

**Carrier's Austin Representative**

Box Number 01

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Central Park Surgery Center was informed by the performing doctor's office that surgery was approved for [injured employee], authorization #846XX. Services were provided to the injured claimant on January 14, 2016. The facility received denial which stated that the authorization was for Westlake Medical Center. The adjuster informed us to send reconsideration to her with a letter from doctor stating that the services took place at Central Park Surgery Center. The facility submitted all information to adjuster and the claim denied again for the same reason. The adjuster stated that they cannot do anything about this and we need to contact the Division of Workers Compensation."

**Amount in Dispute:** \$18,256.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Respondent's utilization review agent preauthorized an open internal fixation (ORIF) to repair the injured employee's [injury] on January 11, 2016. At no time during the preauthorization process was Requestor identified by the surgeon, John Pearce, M.D., as the facility where the surgery was to occur. Consequently, Requestor is not entitled to reimbursement from Respondent."

**Response Submitted by:** Creative Risk Funding

#### SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
January 14, 2016	23615 – Facility Charges	\$18,256.00	\$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 preauthorization, concurrent review, and voluntary certification of healthcare.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 15 – The authorization number is missing, invalid, or does not apply to the billed services or provider
  - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
  - W3 – This is a reconsideration of DCN151xxx. “Original decision maintained” Facility change requested however it still does not appear to be the facilities where services rendered.

**Issues**

1. Did the requestor obtain preauthorization pursuant to 28 Texas Administrative Code §134.600?
2. Is the requestor entitled to reimbursement?

**Findings**

1. The requestor seeks reimbursement for facility charges rendered on January 14, 2016. The insurance carrier denied the disputed services with denial reason code “15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.”

28 Texas Administrative Code §134.600(c) (1) (B) states in pertinent part, “(c) 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... (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care...”

28 Texas Administrative Code §134.600 states in pertinent part, “(f) The requestor or injured employee shall request and obtain preauthorization from the insurance carrier prior to providing or receiving health care listed in subsection (p) of this section. Concurrent utilization review shall be requested prior to the conclusion of the specific number of treatments or period of time preauthorized and approval must be obtained prior to extending the health care listed in subsection (q) of this section. The request for preauthorization or concurrent utilization review shall be sent to the insurance carrier by telephone, facsimile, or electronic transmission and, include the... (8) facility name, and the facility’s national provider identifier if the proposed health care is to be rendered in a facility; and...”

2. Review of the submitted documentation finds that the disputed services were not rendered in the preauthorized facility, Westlake Medical Center. As a result, reimbursement cannot be recommended to the requestor.

**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	Date
		June 24, 2016

***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.***