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
ALLEN ANESTHESIA ASSOCIATES PA

MFDR Tracking Number
M4-18-3186-01

MFDR Date Received
May 1, 2018

Respondent Name
EMPLOYERS MUTUAL CASUALTY COMPANY

Carrier's Austin Representative
Box Number 19

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These claims denied due to precertification/authorization/notification absent due to treating physician not obtaining pre-auth... He had to have anesthesia for these services to be performed safely and without pain. We have the utmost confidence that this claim will reprocess in the best interest of the patient."

Amount in Dispute: $1,530.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier has disputed the bill because the underlying surgical procedure was conducted without preauthorization as required by 28 TAC 134.600. The procedure was performed 14 days after the injury event and none exception to the preauthorization requirement set out is 28 TAC 134.600 (c) are applicable. Carrier asserts that no reimbursement is owed for these services."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
November 7, 2017	01810-QK x 2	$1,530.00	$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

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 review, and voluntary certification of healthcare.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Preauthorization/authorization/certification absent
   - 96 – Non-covered charge(s)
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Are the insurance carrier's denial reason(s) supported?
2. Did the requestor obtain preauthorization for the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for anesthesia services rendered on November 7, 2017. The insurance carrier in the position summary states in pertinent part, "Carrier has disputed the bill because the underlying surgical procedure was conducted without preauthorization as required by 28 TAC 134.600."

   The requestor states in pertinent part, "He had to have anesthesia for these services to be performed safely and without pain. We have the utmost confidence that this claim will reprocess in the best interest of the patient."

2. 28 Texas Administrative Code §134.600 (p) states in pertinent part, "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."

   28 Texas Administrative Code §134.600 (p) (12) states in pertinent part "(p) Non-emergency health care requiring preauthorization includes: (12) treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits)."

   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..."

   The Division finds that the requestor submitted insufficient documentation to support that preauthorization was obtained for the disputed service. As a result, reimbursement cannot be recommended for CPT Code 01810-QK, rendered on November 7, 2017.

3. Review of the submitted documentation finds that the requestor did not obtain preauthorization for the disputed services, as a result, 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

Signature	Medical Fee Dispute Resolution Officer	July 26, 2018 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.