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
Advance Orthopaedics

Respondent Name
TX Public School WC Project

MFDR Tracking Number
M4-18-4991-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
August 16, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We feel since we were authorized to give the item, that authorization should be honored, for the date of service the patient was examined and received the item. Please see supporting documentation to show proof of authorization submission and supporting medical necessity."

Amount in Dispute: $995.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent contends that Requestor provided durable medical equipment in excess of $500 to the injured employee prior to filing a request for preauthorization in this claim. Moreover, given that Requestor provided the Jay Walker boot to the injured employee on May 15, 2018, it exceeded the preauthorization window of service dates outlined in IMO's letter. For these reasons, Respondent is not liable for the disputed services."

Response Submitted by: Creative Risk Funding Inc

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 15, 2018	L4360	$995.00	$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 requirements for prior authorization.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 198 – Payment denied/reduced for exceeded precertification/authorization

- 193 – Original payment decision is being maintained

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 198 – "Payment denied/reduced for exceeded precertification/authorization." 28 Texas Administrative Code §134.600 (p)(9) states,

   Non-emergency health care requiring preauthorization includes:

   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 the requestor requested prior authorization on May 15, 2018 via fax. However, the "Preauthorization Determination Letter" from IMO indicates a received date of May 18, 2018. The authorized dates of service were from May 18, 2018 to June 30, 2018. The date of service submitted on the medical bill in dispute is May 15, 2018. The Division concludes the requirements of 28 Texas Administrative Code 134.600 (p)(9) were not met. The carrier's denial is supported. No additional payment 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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		September 19, 2018
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §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 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. **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.