TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctors Hospital at Renaissance

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-19-0564-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
October 2, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Doctors Hospital at Renaissance obtained authorization # 187794 for CPT Codes 26727, 29125 & 76000, but at the time of procedure Dr. Sergio Rodriguez changed to CPT Code 26735."

Amount in Dispute: $5,410.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Preauthorization obtained under (187794 (Exhibit A) determined medical necessity for procedure codes 26727, 29125 and 76000. In review of the charges billed it was determined that the facility did not bill for the procedure codes and/or services there were preauthorized."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 19, 2018	Outpatient Hospital Services	$5,410.00	$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 requirements for prior authorization.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Payment denied/reduced for absence of precertification/authorization

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 197 – "Payment denied/reduced for absence of precertification/authorization."

   28 Texas Administrative Code §134.600 (p) (2) states in pertinent parts,

   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 information finds the services authorized were 26727 – "Percutaneous skeletal fixation of unstable phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with manipulation, each," 29125 – "Application of short arm splint (forearm to hand); static," and 76000 – "Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time."

   Review of the submitted medical bill found the primary procedure billed was 26735 – "Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, includes internal fixation, when performed, each."

   Insufficient evidence was found to support the health care provider met the prior authorization requirements of 28 TAC 134.600 (p) for the services rendered and billed on date of service July 19, 2018. The insurance carrier's denial reason is supported. Additional 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 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

		October 26, 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.