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
MHHS Hermann Hospital

Respondent Name
XL Insurance America Inc

MFDR Tracking Number
M4-19-3510-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 20, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…the attached bill has been denied for no authorization. However, our client did receive a verbal authorization to perform this procedure from a representative at OneCall."

Amount in Dispute: $4,976.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor was required to obtain authorization from the insurance carrier prior to providing the MRI. See Division rule 134.600 (f). Requesting preauthorization from the carrier, could include requesting preauthorization from the carrier or TPA's Utilization Review Agent. However, in this case ONECALL is not a Utilization Review Agent that is either employed or contracted by the carrier or the TPA."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 3, 2018	72195	$4,976.50	$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
   - 5264 – Payment is denied-service not authorized

Issues

Is the insurance carrier's reason for denial of payment supported?

Findings

The insurance carrier denied disputed services as lack of prior authorization. 28 Texas Administrative Code §134.600 (p) (8) (A) states in pertinent part,

> Non-emergency health care requiring preauthorization includes:
>
> (8) unless otherwise specified in this subsection, a repeat individual diagnostic study:
>
> (A) with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline

To determine the applicable Medical Fee Guideline, 28 TAC §134.403, (f) states,

> The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register.* The following minimal modifications shall be applied.
>
> (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
>
> (A) 200 percent

- Procedure code 72195 is assigned APC 5523. The OPPS Addendum A rate is $232.31, multiplied by 60% for an unadjusted labor amount of $139.39, in turn multiplied by the facility wage index of 0.972 for an adjusted labor amount of $135.49. The non-labor portion is 40% of the APC rate, or $92.92. The sum of the labor and non-labor portions is $228.41. The Medicare facility specific amount of $228.41 is multiplied by 200% for a MAR of $456.82.

Based on the fee calculation shown above, prior authorization was required. However, insufficient evidence was found to support that prior authorization was obtained. The insurance carrier's denial is supported.

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

Signature	Medical Fee Dispute Resolution Officer	April 19, 2019 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.