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

**MFDR Tracking Number**

M4-19-4610-01

**MFDR Date Received**

June 24, 2019

**Respondent Name**

TEXAS MUTUAL INSURANCE COMPANY

**Carrier's Austin Representative**

Box Number 54

**Response Submitted By**

No response received

## *REQUESTOR'S POSITION SUMMARY*

"Based on CPT Code 73560, allowed amount of $55.66, multiplied at 200% and CPT code G0463, allowed amount of $103.51, multiplied at 200%, reimbursement should be $318.34."

## *RESPONDENT'S POSITION SUMMARY*

The insurance carrier did not submit a response for consideration in this review.

## *SUMMARY OF DISPUTE*

| Dates of Service | Disputed Services | Dispute Amount | Amount Due |
|---|---|---|---|
| April 10, 2019 | Outpatient Hospital Services | $221.11 | $0.00 |

## *AUTHORITY*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the hospital facility fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT
   - 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
   - 786 - DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN ACCORDANCE WITH THE NETWORK CONTRACT.
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - DC4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION. FOR INFORMATION CALL (800) 859-5995 X3994.
   - 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

Are the insurance carrier's reasons for denial of payment supported?

Findings

The workers' compensation insurance carrier, Texas Mutual Insurance Company, was notified and acknowledged receipt of a copy of the MFDR request on July 3, 2019.

28 Texas Administrative Code §133.307(d)(1) provides that if the division does not receive a response within 14 calendar days of dispute notification, the division may base its decision on the available information.

To date, no response has been received. Accordingly, this decision is based on information available at the time of review.

The insurance carrier denied disputed services with claim adjustment reason codes:

- 197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT
- 786 - DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN ACCORDANCE WITH THE NETWORK CONTRACT.

Per 28 Texas Administrative Code §134.600(c)(1), the insurance carrier is liable for all reasonable and necessary medical costs relating to the health care … only when the following situations occur:

(A) an emergency, as defined in Chapter 133…
(B) preauthorization of any health care listed in subsection (p)…
(C) concurrent utilization review of any health care listed in subsection (q)…
(D) when ordered by the commissioner

28 TAC §134.600(p)(2) requires preauthorization for non-emergency outpatient surgical services.

Review of the submitted information finds no documentation to support that the disputed services were preauthorized. Additionally, no information was found to support a medical emergency. Consequently, the insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

Conclusion

For the reasons above, the requestor failed to establish that additional payment is due. The amount ordered is $0.00.

## *ORDER*

In accordance with Texas Labor Code §413.031, based on the information submitted for review, DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

| ______________________________ | Grayson Richardson | September 13, 2019 |
|---|---|---|
| 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 28 TAC §133.307.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). DWC must receive the request within twenty days of your receipt of this decision.

You may fax, mail or personally deliver the request to either the field office handling the claim or to DWC at the contact information on the form. You must send a copy to all other parties in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** along with any other information required by 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.