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
MCALLEN INDEPENDENT SCHOOL DISTRICT

MFDR Tracking Number
M4-19-4713-01

Carrier's Austin Representative
Box Number 29

MFDR Date Received
June 28, 2019

Response Submitted By
No response received

REQUESTOR'S POSITION SUMMARY

"We rendered services on good faith based on the information that was exchanged and therefore are also requesting that our claim be reprocessed for payment."

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
March 14, 2019	Outpatient Hospital Services: CPT 20610	$442.22	$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:
   - T197 – Payment denied/reduced for absence of, or exceeded, precertification and/or authorization.
   - T113 – Level 1 appeal means a request for reconsideration under 133.250.
   - P15 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

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

Findings

The Austin carrier representative for McAllen Independent School District is Dean G. Pappas Law Firm, LLC, who acknowledged receipt of a copy of the MFDR request on July 8, 2019.

28 Texas Administrative Code §133.307(d)(1) provides 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. Consequently, this decision is based on the information available at the time of review.

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

- T197 – Payment denied/reduced for absence of, or exceeded, precertification and/or authorization.

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.

CPT code 20610 represents a surgical service and therefore requires authorization for non-emergency treatment.

Review of the submitted information finds no documentation to support that the disputed service was 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.