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
DOCTORS HOSPITAL AT RENAISSANCE

Respondent Name
HIDALGO COUNTY

MFDR Tracking Number
M4-19-4998-01

Carrier's Austin Representative
Box Number 21

MFDR Date Received
July 26, 2019

Response Submitted By
IMO, Injury Management Organization, Inc.

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

"Based on the submitted documentation no additional allowance is being allowed."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 4, 2019 to March 11, 2019	Outpatient Physical Therapy	$1,032.24	$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.

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 rules regarding preauthorization of health care.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 96 – NON-COVERED CHARGE(S).
   - 198 – PAYMENT DENIED/REDUCED FOR EXCEEDED PRECERTIFICATION/AUTHORIZATION.
   - 246 – THIS NON-PAYABLE CODE IS FOR REQUIRED REPORTING ONLY.
   - 797 – SERVICE NOT PAID UNDER MEDICARE OPPS.
   - W3 – RECONSIDERATION

Issue

Did the health care provider obtain preauthorization for the disputed service?

Findings

The insurance carrier denied disputed the services with reason code 198 – "PAYMENT DENIED/REDUCED FOR EXCEEDED PRECERTIFICATION/AUTHORIZATION."

28 Texas Administrative Code §134.600(c), requires the carrier to be liable for all reasonable and necessary medical costs relating to health care only in the case of:

(A) an emergency, as defined in Chapter 133…

(B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care.

Rule §134.600(p) states, non-emergency health care requiring preauthorization includes:

(5) physical and occupational therapy services

The requestor presented a preauthorization approval letter effective for services beginning April 18, 2019; however, the effective dates for the authorization are later than the dates of the services in dispute.

No documentation was found to support the disputed services (from March 4, 2019 to March 11, 2019) had been preauthorized. Nor did the requestor present any documentation to support a medical emergency.

The insurance carrier's denial reason is supported. Reimbursement is not recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above, the division finds the requestor has not established that additional payment is due. As a result, the amount ordered is $0.00.

ORDER

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

Authorized Signature

Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	August 9, 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.

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 form's instructions. The division must receive the request within twenty days of your receipt of this decision. The request may be faxed, mailed or personally delivered either to the division, using the contact information listed on the form, or to the field office handling the claim.

The party seeking review must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Include a copy of this *Medical Fee Dispute Resolution Findings and Decision*** together with any other information required by 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.