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
WADLEY REGIONAL MEDICAL CENTER

Respondent Name
MARKEL INSURANCE COMPANY

MFDR Tracking Number
M4-19-5036-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
July 30, 2019

Response Submitted By
Downs Stanford, P.C.

REQUESTOR'S POSITION SUMMARY

The requestor did not submit a position statement for consideration in this review.

RESPONDENT'S POSITION SUMMARY

"Respondent preauthorized specific CPT codes… However, Requestor performed a different procedure, and billed it under CPT code 23415. This procedure was not preauthorized, and it was denied by Respondent for that reason."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 6, 2019	Outpatient Surgery: CPT 23415	$5,683.34	$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 §134.403 sets out the hospital facility fee guideline for outpatient services.
3. 28 Texas Administrative Code §134.600 sets out requirements regarding authorization of health care.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - C45 – DENIED: PER CARRIER, PRE-AUTHORIZATION NOT REQUESTED.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 350 – BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

Was the disputed service preauthorized?

Findings

The insurance carrier denied disputed services with claim adjustment reason code C45 – "DENIED: PER CARRIER, PRE-AUTHORIZATION NOT REQUESTED."

28 Texas Administrative Code §134.600(p)(2) states that non-emergency health care requiring preauthorization includes: "outpatient surgical or ambulatory surgical services…"

No documentation was found to support a medical emergency; therefore, the disputed outpatient surgical service required preauthorization. Review of the submitted information finds no documentation to support that disputed CPT code 23415 was preauthorized.

The insurance carrier's denial reason is supported. Additional payment cannot be 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

	Grayson Richardson	August 23, 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 Rule §133.307.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). 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 field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute 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.