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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
LASER SURGERY HOLDING COMPANY, LTD

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-20-0686-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
NOVEMBER 13, 2019

REQUESTOR'S POSITION SUMMARY

"Claim was denied by Texas Mutual, noting that the authorization was only approved until 06/26/2019. Member's date of service was a few days past the end date on 07/01/2019. We have determined that per the worker's comp guidelines, there is no agreement between provider and payer. Prior auth was first approved based on medical necessity proven through all medical documentation submitted from the physician's office. Therefore, per our dispute, we request that claim be reviewed and reprocessed for appropriate payment as services billed were medically necessary."

Amount in Dispute: $70,000.00

RESPONDENT'S POSITION SUMMARY

"Laser Surgery Center/Dr. Patel obtained preauthorization (Attachment). The procedure is noted to be completed on or before 4/26/19-6/26/19. Treatment or procedures are to be completed within the agreed upon time period. Further review of the claim file and or preauthorization does not show the provider attempted to obtain an extension of preauthorization beyond 6/26/19. The provider rendered services outside of approved dates. No payment is due."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 1, 2019	Ambulatory Surgical Care Services (ASC) CPT Code 63685	$70,000.00	$0.00

FINDINGS AND DECISION

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

Background

1. 28 Texas Administrative Code §133.307 (TAC), effective May 31, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.

3. 28 TAC §134.600, effective March 30, 2014, requires preauthorization for specific treatments and services.
4. Per the submitted explanation of benefits, the services in dispute were reduced/denied by the respondent with the following claim adjustment reason codes:
   - CAC-197-Precertification/authorization/notification absent.
   - 930-Pre-authorization required. Reimbursement denied.
   - CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration.
   - 891-No additional payment after reconsideration.
   - CAC-193-Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly.

Issues

Is the requestor entitled to reimbursement for ASC services rendered on July 1, 2019?

Findings

1. The requestor provided ASC services in the state of Arizona on July 1, 2019 to an injured employee with an existing Texas Workers' Compensation claim. The requestor was dissatisfied with the respondent's final action. The requestor filed for dispute resolution under 28 TAC §133.307. The DWC concludes that because the requestor sought the administrative remedy outlined in 28 TAC§133.307 for resolution of the matter of the request for payment, the dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules.
2. The requestor is seeking medical fee dispute resolution in the amount of $70,000.00 for ambulatory surgical care services rendered to the injured worker on July 1, 2019.
3. The respondent denied reimbursement for the disputed services based upon a lack of preauthorization.
4. Per 28 TAC §134.600(f) (1-3), "The requestor or injured employee shall request and obtain preauthorization from the insurance carrier prior to providing or receiving health care listed in subsection (p) of this section. Concurrent utilization review shall be requested prior to the conclusion of the specific number of treatments or period preauthorized and approval must be obtained prior to extending the health care listed in subsection (q) of this section. The request for preauthorization or concurrent utilization review shall be sent to the insurance carrier by telephone, facsimile, or electronic transmission and, include the:

   (1) name of the injured employee;

   (2) specific health care listed in subsection (p) or (q) of this section;

   (3) number of specific health care treatments and the specific period requested to complete the treatments."
5. 28 TAC §134.600(p)(2) requires preauthorization for "(2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section."

   The DWC finds the disputed services required preauthorization because are listed in subsection (P)(2) - ambulatory surgical care services.

   On April 26, 2019, gave preauthorization approval for outpatient spinal cord stimulator replacement to be done at Laser Surgery Center between April 26, 2019 and June 26, 2019.

   The DWC finds the respondent's denial of payment is supported because the services were rendered outside of the preauthorized period.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the DWC has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		12/11/2019
Signature	Medical Fee Dispute Resolution Officer	Date
		12/11/2019
Signature	Director of Medical Fee Dispute Resolution	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, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

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