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
UT Health Tyler

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-20-0855-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
December 9, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please review the MFDR Request with the authorization attached. The bill and appeal were denied for lacking authorization."

Amount in Dispute: $66,977.23

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Preauthorization was not obtained for inpatient treatment or length of stay, the carrier maintains its position regarding denial for preauthorization."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 30, 2019 through May 6, 2019	Inpatient hospital services	$66,977.23	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 requirements of prior authorization.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
   - 198 – Precertification/authorization exceeded
   - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information

Issues

1. Is the requestors' position supported?

Findings

1. The requestor states, "Please review the MFDR Request with the authorization attached." Review of the attached authorization dated April 3, 2019 indicates certification of "Outpatient Barium Enema code 74270."

   The services in dispute is for and inpatient hospital stay that began on April 30, 2019 and ended May 6, 2019 which the medical record indicates the procedure performed was Colostomy reversal and colocolonic anastomosis.

   28 TAC §134.600 (p) states non-emergency health care requiring preauthorization includes inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay. Insufficient evidence was found to support authorization for the services in dispute. No additional payment is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC 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 requestor has not established payment is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

[redacted]
Signature — Medical Fee Dispute Resolution Officer — January 24, 2020 — Date

[redacted]
Signature — Director of Medical Fee Dispute Resolution — January 24, 2020 — 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, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **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.