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
PHYSICIANS SURGICAL HOSPITAL

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-20-0976-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
DECEMBER 16, 2019

REQUESTOR'S POSITION SUMMARY

Position statement was not submitted.

Amount in Dispute: $10,094.52

RESPONDENT'S POSITION SUMMARY

"The Office performed an in-depth review of the dispute packet submitted by the Physicians Surgical Hospital, where the Office will maintain its denial for ANSI code 197-Payment denied/reduced for absence of precertification/preauthorization for dates of service 8/13/2019, as the providfer performed services prior to preauthorization to be certified."

Response Submitted by: State Office of Risk Management (SORM)

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 13, 2019	Outpatient Surgical Services Revenue Codes 250-710	$10,094.52	$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 TAC §134.600, effective November 1, 2018, requires preauthorization for specific treatments and services.
3. Per the submitted explanation of benefits, the services in dispute were reduced/denied by the respondent with the following claim adjustment reason codes:
   - 197-Payment denied/reduced for absence of precertification/authorization.
   - 4915-The charge for the services represented by the revenue code are included/bundled into the total facility payment and do not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment.

- 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- W3-Additional payment made on appeal/reconsideration.
- 193-Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly.

Issues

1. Does a preauthorization issue exist?
2. Is the requestor entitled to reimbursement for outpatient surgical services rendered on August 13, 2019?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $10,094.52 for outpatient hospital services rendered to the injured worker on August 13, 2019.
2. The insurance carrier denied reimbursement for the disputed services based upon "197-Payment denied/reduced for absence of precertification/authorization."

   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."

   28 TAC §134.600(p)(2) requires preauthorization for "(2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section."

   Per 28 TAC §134.600(f)(2) the disputed services required preauthorization because are a specific health care listed in subsection (P)(2) – outpatient surgical services.

   A review of the submitted documentation finds no documentation to support preauthorization was obtained for the disputed services; therefore, the respondent's denial of payment is supported

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

Authorized Signature

		01/14/2020
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, 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.