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
ST. JOSEPH MEDICAL CENTER

Respondent Name
TEXAS CITY ISD

MFDR Tracking Number
M4-20-1761-01

MFDR Date Received
March 18, 2020

Carrier's Austin Representative
Box Number 49

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Effective March 1, 2008, the State of Texas revised its Medical Fee Guidelines governing workers compensation reimbursement of medical services. The purpose of this letter is to inform you that payment for services provided to the above reference patient does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code."

Amount in Dispute: $5,253.31

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill in question was denied payment since these services were not Preauthorized as required by Rule 134.600. Attached you will find the initial submission for Pre-authorization on 10/14/19 and the 10/16/19 response from The Reny Company informing the parties that 'medical necessity has NOT been substantiated'. There was no request for reconsideration submitted, therefore, we stand by our non-payment for these services as stated on the Explanation of Review dated 11-13-2019.

Response Submitted by: The Littleton Group

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
October 17, 2019	Outpatient Facility Charges	$5,253.31	$0.00

FINDINGS AND DECISION

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

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 28 TAC §134.203 sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Preauthorization/authorization/certification absent
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Was the requestor required to obtain preauthorization for the services in dispute?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for outpatient facility charges, rendered on October 17, 2019. The insurance carrier in the position summary states in pertinent part, "The bill in question was denied payment since these services were not Preauthorized as required by Rule 134.600…"

   28 TAC §134.600 (p) (12) states in pertinent part "(p) Non-emergency health care requiring preauthorization includes… (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section…"

   28 TAC §134.600 (c) (1) (B) states in pertinent part, "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur... (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care..."

   Review of the documentation submitted with the DWC060 supports that the provider requested preauthorization for the scheduled procedure and preauthorization was denied. The provider performed and billed the disputed services which were subsequently denied by the insurance carrier with denial reduction code 197 -Preauthorization/authorization/ certification absent. The DWC finds that preauthorization was required for the scheduled outpatient surgical procedure, as a result reimbursement cannot be recommended for date of service October 17, 2019.
2. Review of the submitted documentation finds that preauthorization was required and not obtained, as a result the DWC has determined that the requestor is entitled to $0.00 for the services in dispute.

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 TLC §413.031, the DWC has determined that the requestor is not entitled to reimbursement for the disputed services.

Authorized Signature

______________________	______________________	March 31, 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 habl ar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.