TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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# ` MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
MHHS the Woodlands Hospital

**Respondent Name**
City of Houston

**MFDR Tracking Number**
M4-21-1006-01

**Carrier's Austin Representative**
Box Number 29

**MFDR Date Received**
February 23, 2021

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Please see the attached medical fee dispute and require the carrier to accept this as a Work related claim set up and pay per Texas fee schedule."

**Amount in Dispute:** $3,064.50

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Based on the review of the bills history it was found the denial of lack of preauthorization for the dates of service submitted is appropriate."

**Response Submitted by:** Injury Management Organization, Inc

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| March 2 – 19, 2020 | Cardiac Rehab | $3,064.50 | $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 outs the requirements of prior authorization.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – Payment denied/reduced for absence of precertification/authorization
   - 29 – The time limit for filing has expired
   - 4271 – Per TX labor Code Sec 413.016, providers must submit bills to payors within 95 days of the date of service

**Issues**

Is the insurance carrier's denial of payment supported?

**Findings**

The requestor is seeking reimbursement of rehabilitation services rendered in March 2020. The insurance carrier denied the disputed service based on lack of preauthorization.

28 TAC §134.600 (p)(9)(5) (A) states in pertinent part non-emergency health care requiring preauthorization includes physical medicine and rehabilitation.

Review of the submitted documentation found the authorization for the rehabilitation services ended February 28, 2020. Insufficient evidence was found to support that an extension of the authorization. The carrier's denial is supported.

No 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**

| | | |
|---|---|---|
| | | March 12, 2021 |
| 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, 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**.