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 and Address

SOUTH TEXAS RADIOLGY IMAGING CENTER
PO BOX 29490
SAN ANTONIO TX 78229-0490

Respondent Name
Travelers Indemnity Company

Carrier's Austin Representative Box
Box Number 05

MFDR Tracking Number
M4-12-1508-01

MFDR Date Received
January 6, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Patient stated services which were provided were covered under worker's compensation claim."

Amount in Dispute: $380.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "… the full procedure requires preauthorization under Rule 134.600(p)(2), as acknowledged by the Claimant's doctor in making the preauthorization request. Review of that request by a physician advisor determined the request did not meet medical necessity criteria, and the request was denied. As preauthorization was not obtained prior to performing the services at issue, the Provider is not entitled to reimbursement. Therefore, under Rule 134.600(c), the Carrier is not liable for reimbursement for the services rendered."

Response Submitted by: Travelers Indemnity Company, 1501 S. Mopac Expressway, Suite A-320, Austin, TX 78746

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 4, 2011	Professional Services	$380.06	$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.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.600 sets out the guidelines for prospective review of health care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION.
   - W4 – NO ADDITIONALY REIMBURSEMENT ALLOWED AFTER REVIEW OF

APPEAL/RECONSIDERATION.

Issues

1. Did the requestor obtain authorization prior to providing the services in dispute?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the services in dispute as 197 – "PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION". Per 28 Texas Administrative Code §134.600(c)(1), effective May 2, 2006, 31 *Texas Register 3566,* the carrier is liable for all reasonable and necessary medical costs relating to the health care listed in subsection (p) only in the case of an emergency or "preauthorization of any health care listed in subsection (p) … that was approved prior to providing the health care." 28 Texas Administrative Code §134.600(p)(2) states that the non-emergency health care requiring preauthorization includes "outpatient surgical or ambulatory surgical services." Documentation was found that supports a prior authorization request was made but denied. Therefore, the carrier's denial is supported.
2. Review of the submitted documentation finds that the prior authorization guidelines were not met. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional 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 Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 25, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

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