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
SHANNON MEDICAL CENTER

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-14-1774-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
February 19, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We requested they submit this claim for the additional allowance for this treatment room charge, you have denied this for no authorization, per rule 134.600 section P clinic and treatment rooms require no authorization, hence this line should process for payment. We submitted an appeal and the carrier has [sic] stayed with their original payment. This carrier seems to use the 'Medical Necessity' denial as a way to not pay clinic charges, and we feel this should be addressed by TDI, as these clinic codes need no authorization, medical necessity should not be valid denial."

Amount in Dispute: $133.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In review of the dispute packet submitted by the requestor Shannon Medical Center, the Office will maintain our denial for date of service 2/19/13 where the provider billed a 99212-TC with ANSI code 50-These are non-covered services because this is not deemed a medical necessity by the payer and T13-Medical Necessity denial as Hospital/Facilities cannot charge carrier for doctors using their room for services and W2-Payment reduced or denied based on worker's compensation jurisdictional regulations or payment policies. Furthermore the Office visit CPT code 99212 is considered a professional code and should be billed on a CMS-1500 as there is no technical component for an Office visit or consult in a hospital setting."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 19, 2013	99212-TC	$133.90	$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 §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting an Independent Review Organization (IRO).

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer
   - T13 – Medical necessity denial. You may submit a request for appeal/reconsideration no later than 10 months from the date of service
   - W2 – Workers' Compensation Claim adjudicated as non-compensable. Carrier not liable for claim or service/treatment.
   - 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.

Issues

1. Did the requestor file for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Is the requestor eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. The requestor filed a dispute with the Medical Fee Dispute Resolution section at the Division on February 19, 2014. According to 28 Texas Administrative Code §133.305(a)(4), a medical fee dispute is a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury.

   28 Texas Administrative Code §133.305(b) goes on to state in relevant part that "If a dispute regarding... medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding... medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021."

   28 Texas Administrative Code §133.307(e) (3) (G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General).

   The appropriate dispute process for unresolved issues of medical necessity requires the filing of an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. No documentation was submitted to support that the issue(s) of medical necessity have been resolved as of the undersigned date.
2. The requestor has failed to support that the services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning medical necessity have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 413 prior to the submission of a medical fee dispute for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

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

		August 8, 2014
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 Texas Administrative Code §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 Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division 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 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 §141.1(d).

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