



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

GEORGE GALVAN, MD

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number

M4-17-0256-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

January 18, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This situation is emergent due to the fact this gentleman presented with a worsening neurological exam with known acute spinal cord injury and known spinal cord compression as the cause."

Amount in Dispute: \$36,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual has no record the requestor obtained preauthorization prior to surgery of 1/18/16. Nor does the documentation substantiate a medical emergency as defined by Rule 133.2."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Dispute Amount, Amount Due. Row 1: January 18, 2016, Professional Services - Surgery, \$36,000.00, \$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 §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §133.210 sets out requirements regarding medical documentation.
4. Insurance Code §1305.004 defines terms related to workers' compensation health care networks.
5. Insurance Code §1305.153 sets out requirements regarding payment of network and non-network providers.
6. Insurance Code §1305.351 provides that preauthorization requirements of Labor Code §413.014 and division rules adopted under that section, do not apply to health care provided through a workers' compensation network.
7. The requestor is a non-network provider that rendered approved out-of-network treatment to a network claimant. Pursuant to Texas Insurance Code §1305.153(c), out-of-network providers shall be reimbursed as provided by the Texas Workers' Compensation Act and division rules.

8. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
 - 197 - PRECERTIFICATION/AUTHORIZATION ABSENT
 - 786 - DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN ACCORDANCE WITH THE NETWORK CONTRACT.
 - 899 - DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes:
 - 197 - PRECERTIFICATION/AUTHORIZATION ABSENT
 - 786 - DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN ACCORDANCE WITH THE NETWORK CONTRACT.
 - 899 - DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2.

Labor Code Sec. 1305.351(c) states that:

The preauthorization requirements of Section 413.014, Labor Code, and commissioner of workers' compensation rules adopted under that section, do not apply to health care provided through a workers' compensation network. If a network or carrier uses a preauthorization process within a network, the requirements of this subchapter and commissioner rules apply. A network or an insurance carrier may not require preauthorization of treatments and services for a medical emergency.

Accordingly, no preauthorization was required for the disputed services under division rules or the Labor Code. The insurance carrier has therefore failed to support denial reason code 197 regarding preauthorization.

The requestor submitted a copy of a letter of approval supporting that the health care provider had requested and received "Out of Network Authorization to Treat Injured Worker Covered by the Texas Star Network."

The letter states, "Please note, this approval for OON treatment does not preempt obtaining preauthorization for procedures under the network guidelines." However, the insurance carrier did not present any information to support a preauthorization process within the network pursuant to Labor Code §1305.351(c), or to support that preauthorization was required for the disputed services under network guidelines or by contract.

Rule §133.307(d)(2)(D) requires the insurance carrier's response to include a copy of any "pertinent medical records or other documents relevant to the fee dispute not already provided by the requestor."

Rule §133.307(d)(2)(E)(iv) requires the insurance carrier's response to discuss "how the submitted documentation supports the respondent's position for each disputed fee issue."

Rule §133.307(d)(1) provides that if the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

The division emphasizes that this decision is based on all available information submitted by the parties to this dispute up to the time of review.

The respondent did not provide any documentation of network guidelines to support that preauthorization was required for the disputed services. Nor did the respondent provide any documentation to support "preauthorization denial in accordance with network contract." Consequently, the respondent has failed to support denial code 786.

With regard to the insurance carrier's denial related to emergency, review of the submitted information finds insufficient information to support an emergency in accordance with the definitions in Insurance Code §1305.004. Nonetheless, an emergency is not a prerequisite for payment under division rules or Insurance Code Chapter 1305. The insurance carrier has therefore failed to support denial code 899.

The division concludes the respondent has failed to support the asserted denial reasons.

2. This dispute regards approved out-of-network treatment provided by a non-network health care provider to an injured employee subject to coverage through a workers' compensation health care network established under Insurance Code chapter 1305. Section 1305.153(c) provides that in such circumstances, out-of-network providers shall be reimbursed as provided by the Texas Workers' Compensation Act and division rules.

Rule §134.203 sets out the division's Medical Fee Guideline for Professional Services.

Rule §133.210(c)(2) requires that medical bills for surgical services (with fees exceeding \$500) shall include a copy of the operative report in addition to other required documentation.

Rule §133.307(c)(2)(M) requires the health care provider to submit with the request for medical fee dispute resolution "a copy of all applicable medical records related to the dates of service in dispute."

Review of the submitted documentation finds no operative report or other medical records to support the disputed services as billed. Based on the submitted information, additional payment cannot be recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the available evidence presented by the requestor and respondent at the time of review. Even though not all the evidence was discussed, it was considered.

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 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

_____	_____	_____
Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	March 29, 2018 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.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.