TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS HEALTH ROCKWALL REGIONAL HOSPITAL

Respondent Name
CONTINENTAL INSURANCE COMPANY

MFDR Tracking Number
M4-18-2292-01

Carrier's Austin Representative
Box Number 57

MFDR Date Received
February 27, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our facility was initially unaware of a workers' compensation claim and billed to Medicare."

Amount in Dispute: $40,758.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "No Proof of Preauthorization . . . Services Not Provided by an authorized Provider . . . Untimely Submittal of Bill within 95 days of service . . . The requestor is not eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307."

Response Submitted by: Law Office of Brian J. Judis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
May 22, 2017	Outpatient Hospital Services	$40,758.98	$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 §133.240 sets out requirements regarding medical bill payments and denials.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective review of health care.
4. Insurance Code Chapter 1305 sets out requirements regarding workers' compensation health care networks.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 242 – Services not provided by network/primary care providers.
   - 197 – Precertification/authorization/notification absent.
   - W3 – Request for reconsideration.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. What is the date of service in dispute?
2. Did the respondent raise new denial reasons or defenses in their position statement that were not presented to the health care provider prior to the filing of the request for medical fee dispute resolution?
3. Are the service subject to a certified workers' compensation health care network established in accordance with Insurance Code Chapter 1305?
4. Did the disputed outpatient surgical services require preauthorization?

Findings

1. The requestor listed February 22, 2017 as the disputed date of service on the submitted *Table of Disputed - Services* in the DWC-60 request form for medical fee dispute resolution. However, review of the submitted materials finds the services were performed on May 22, 2017. The division therefore takes notice that the date on the requestor's *Table of Disputed -Services* is a typographical error, and will deem the correct date of service to be May 22, 2017. As such, the request was timely submitted to MFDR and is eligible for review.
2. Rule §133.307(d)(2)(F) requires that:

   > The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

   The respondent's position statement raises new denial reasons or defenses that were not listed among the claim adjustment reason codes presented on the submitted explanations of benefits. No documentation was found to support that the respondent presented such reasons or defenses to the requestor prior to the date that the request for medical dispute resolution was filed with the division; therefore, the division concludes that the respondent has waived the right to raise such additional denial reasons or defenses. Any newly raised denial reasons or defenses shall not be considered in this review.
3. The insurance carrier denied disputed services with claim adjustment code:
   - 242 – "Services not provided by network/primary care providers."

   Based on information maintained by the division, the insurance carrier has not reported to the division that this injured employee's claim is subject to a certified workers' compensation health care network (HCN) established in accordance with Insurance Code Chapter 1305.

   Furthermore, Rule §133.240(f)(15) requires the paper form of any explanation of benefits (EOB) to include the workers' compensation health care network name (if applicable). Review of the submitted explanation of benefits denying payment for the disputed bill finds the fields indicating HCN name and HCN ID to be blank. No notice of the name of any certified workers' compensation HCN established in accordance with Insurance Code Chapter 1305 was found elsewhere on the EOB. The division finds the insurance carrier failed to meet the requirements of Rule §133.240(f)(15). Accordingly, the division concludes the respondent has waived the right to assert the claim is subject to a workers' compensation HCN established under Insurance Code Chapter 1305.
4. The insurance carrier denied disputed services with claim adjustment code:
   - 197 – "Precertification/authorization/notification absent."

   28 Texas Administrative Code §134.600(c)(1) requires that the carrier is liable for all reasonable and necessary medical costs relating to the health care listed in subsection (p) or (q) of this section only when the following situations occur:

   (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);
   (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care.

Rule §134.600(p)(2) states that the non-emergency health care requiring preauthorization includes "outpatient surgical or ambulatory surgical services."

This dispute regards outpatient surgical services. Review of the submitted information finds no documentation to support the disputed services were preauthorized. Nor did the requestor present documentation to support a medical emergency. The insurance carrier's denial reason is supported. Reimbursement is not 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

	Grayson Richardson	April 6, 2018
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.

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.