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
OakBend Medical Center

Respondent Name
Houston ISD

MFDR Tracking Number
M4-19-3379-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
March 7, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please note that there are no in-network hospital for this carrier in this area. Therefore OakBend Hospital is submitting all forms of documentation to substantiate the service rendered."

Amount in Dispute: $9,492.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…the provider was given notice that if the services needed to be done after those 50 days, that a new pre-authorization was required for the services. The provider did not request a new pre-authorization notice for the services provided on 03/16/2018, which was a full 14 days past the date range of pre-authorization. As such, the Houston Independent School District has no compulsion to reimburse these services."

Response Submitted by: Novare LLC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 16, 2018	Outpatient hospital services	$9,492.00	$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 §134.600 sets out the requirements for prior authorization.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 15 – Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider

- 810 – Recommended payment of this procedure or supply should be reimbursed only if pre-authorization has been obtained
- 197 – Payment denied/reduced for absence of precertification/authorization

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. The insurance carrier denied disputed services based on the lack of pre-authorization. 28 Texas Administrative Code §134.600 (p) (2) states in pertinent part,

   Non-emergency health care requiring preauthorization includes:

   (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;

   Review of the submitted information finds the insurance carrier included a note on the explanation of benefits, "Authorization time period ran out – specified authorization time period was from 01/11/18 to 03/02/18."

   As the date of service was March 16, 2018, the insurance carrier's denial is supported. No additional payment is 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 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

		April 5, 2019
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 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 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 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.