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 Spine and Joint

Respondent Name
Pacific Employers Insurance Co

MFDR Tracking Number
M4-19-3444-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
March 14, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is reasonable to believe that if a Hospital representative sees preauthorization, they will continue to move forward under the representation that the procedure is authorized."

Amount in Dispute: $13,482.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier did not preauthorize the services in dispute and the Provider proceeded to an IRO review. The IRO upheld the Carrier's denial of preauthorization."

Response Submitted by: The Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 30, 2018	Outpatient hospital services	$13,482.60	$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 §13The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 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 the outpatient services rendered on May 30, 2018 for 13,482.60 as lacking pre-authorization.

   Review of the submitted documentation found an "adverse determination" dated March 5, 2018 that informed the request for services had been denied.

   The insurance carrier's denial is supported as 23 TAC 134.600 (p) (2) states in pertinent parts, "Non-emergency health care requiring preauthorization includes: outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section."

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.