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
MHHS Southeast Hospital

Respondent Name
XL Insurance America Inc

MFDR Tracking Number
M4-19-4754-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 2, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I submitted an appeal letter based on the denial for no authorization due to the patient coming into the Emergency room on 8/21/2018 …and was admitted. This is due to a work related injury."

Amount in Dispute: $54,828.75

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…the provider is not entitled to reimbursement because the services in question required preauthorization, yet the provider did not seek preauthorization."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 21 - 30, 2018	Inpatient Hospital Services	$54,828.75	$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:
   - 197 – Payment denied/reduced for absence of precertification/authorization
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Is the insurance carrier's reason for denial of payment supported?

Findings

1. The requestor is seeking reimbursement for an inpatient hospital stay in the amount of $54,828.75 that began on August 21, 2018 through August 30, 2018. The insurance carrier denied the inpatient stay based on lack of preauthorization.

   28 §TAC 134.600 (p)(1) states in pertinent part,

   (p) Non-emergency health care requiring preauthorization includes:

   (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay;

   Review of the submitted medical bill found the patient came into the emergency room and upon evaluation was admitted into the hospital for over a week.

   Insufficient evidence was found to support that upon admission the health care provider made any attempt to seek prior authorization.

   The insurance carrier's denial for lack of preauthorization is supported.

   The respondent brought up other issues in their response but as none of these were submitted to the health care provider in the form of an explanation of benefits prior to the request for MFDR, the provisions of 28 TAC §133.307 (d) (2) (F) does not allow consideration of these statements.

Conclusion

For the reasons stated above, DWC 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

		September 24, 2019
Signature	Medical Fee Dispute Resolution Officer	Date
		September 24, 2019
Signature	Director of Medical Fee Dispute Resolution	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 DWC 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.