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
MEMORIAL HERMANN SPECIALTY HOSPITAL

Respondent Name
UNITED AIRLINES, INC.

MFDR Tracking Number
M4-20-0156-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 16, 2019

Response Submitted By
No response received from insurance carrier

REQUESTOR'S POSITION SUMMARY

"Please note that prior authorization was obtained which is enclosed for review."

RESPONDENT'S POSITION SUMMARY

The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 19, 2018 to November 28, 2018	Outpatient Hospital Services	$13,012.67	$0.00

AUTHORITY

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the hospital facility fee guideline for outpatient services.
3. 28 Texas Administrative Code §134.600 sets out requirements regarding authorization of health care.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 240 - PREAUTHORIZATION NOT OBTAINED.
   - 356 - THIS OUTPATIENT ALLOWANCE WAS BASED ON THE MEDICARE'S METHODOLOGY (PART B) PLUS THE TEXAS MARKUP.
   - 370 - THE HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
   - 616 - THIS CODE HAS STATUS Q APC INDICATOR AND IS PACKAGED INTO OTHER APC CODES THAT HAVE BEEN IDENTIFIED BY CMS.
   - 618 - THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
   - PDC - THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR COVENTRY CONTRACT. FOR QUESTIONS, PLEASE CALL 1-800-937-6824.
   - 197 - PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT
   - 45 - CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.
   - 97 - THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.

Issues

1. Did the insurance carrier respond to the request for medical fee dispute resolution (MFDR)?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. Was preauthorization required?

Findings

1. The Austin carrier representative for United Airlines, Inc. is Flahive, Odgen & Latson, Attorneys at Law, PC, who acknowledged receipt of a copy of the MFDR request on September 24, 2019. 28 Texas Administrative Code §133.307(d)(1) provides that if the division does not receive a response within 14 calendar days of dispute notification, the division may base its decision on the available information. To date, no response has been received. Consequently, this decision is based on the information available at the time of review.
2. The insurance carrier denied payment for the disputed services with claim adjustment codes:
   - 45 - CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.
   - PDC - THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR COVENTRY CONTRACT. FOR QUESTIONS, PLEASE CALL 1-800-937-6824.

   No information was presented to support a contracted fee arrangement between the parties to this dispute.

   While under Texas labor Code §408.031, "an injured employee may receive benefits under a workers' compensation health care network (HCN) established under Chapter 1305, Insurance Code;" no information was presented to support that reimbursement is subject to the provisions of a certified workers' compensation HCN established under Insurance Code Chapter 1305.

   Rule 28 TAC §133.240(f)(15) requires the insurance carrier's explanation of benefits to include the "workers' compensation health care network name (if applicable)."

   Review of the submitted explanation of benefits finds the PPO network listed is "Coventry Integrated Network."

   Based on information maintained by the division, "Coventry Integrated Network" is not the name of any certified workers' compensation HCN established in accordance with Texas Insurance Code Chapter 1305.

   No information was presented to support that the health care provider is contracted with either the alleged network or the insurance carrier directly. No information was presented to support that the insurance carrier was authorized on the date of service to access any contract between the health care provider and a third party.

   The above denial reasons are not supported. Reimbursement for the disputed services is therefore subject to DWC rules and fee guidelines.
3. The insurance carrier denied payment for the disputed services with claim adjustment codes:
   - 240 - PREAUTHORIZATION NOT OBTAINED.
   - 197 - PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT

   This dispute regards outpatient hospital surgical services subject to Rule 28 TAC §134.600(p)(2), which requires non-emergency outpatient surgical services to be preauthorized. No information was found to support a me a medical emergency; therefore, the services were required to be preauthorized.

   The requestor asserts, "Please note that prior authorization was obtained which is enclosed for review." However, upon review, no evidence of prior authorization was found with the submitted documentation.

   The insurance carrier's denial reasons are supported regarding lack of preauthorization for the disputed services. Consequently, additional payment cannot be recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of the division is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

The requestor failed to support that authorization had been obtained for services that require preauthorization. As a result, the amount ordered is $0.00.

ORDER

In accordance with Texas Labor Code §413.031, based on the information submitted for review, DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	October 18, 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 28 TAC §133.307.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). DWC must receive the request within twenty days of your receipt of this decision.

You may fax, mail or personally deliver the request to either the field office handling the claim or to DWC at the contact information on the form. You must send a copy to all other parties in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** along with any other information required by 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.