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
AZALEA ORTHOPEDICS & SPORTS MEDICINE

Respondent Name
EAST TEXAS EDUCATIONAL INS ASSN.

MFDR Tracking Number
M4-21-0437-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
November 13, 2020

Response Submitted by:
Claims Administrative Services, Inc.

REQUESTOR'S POSITION SUMMARY

"Our position is that Azalea Orthopedics could not have obtained authorization because it initially was processing the bill through group health. I have enclosed all relevant documents which show Aetna's initial billing, then our dispute with Claims Administrative Services."

RESPONDENT'S POSITION SUMMARY

"This complaint stems from our denial due to lack of Preauthorization for an outpatient surgical procedure to the right [redacted] They indicate they filed this bill under her health insurance, therefore did not Preauthorize the services under her Workers Compensation claim. We have attached a copy of our first notification to file bills to Claims Administrative Services for her work-related injury. In addition, we have included copies of medical bills filed to us relating to the [redacted] injury as well as prior Preauthorization's for other medical services incurred for the same injury. It is our position that our denial for lack of Preauthorization was correct as the provider has correct carrier information and no benefits would be due for this service. Should there be any questions, please let us know."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 14, 2019	25000-RT	$1,500.00	$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 requirements of prior authorization.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 721 – PER RULE 134.600 OF THE TEXAS ADMINISTRATIVE CODE, THIS PROCEDURE REQUIRES PREAUTHORIZATION, PREAUTHORIZATION NOT OBTAINED.
   - 197 – PRECERTIFICATION/AUTHORIZATION/ NOTIFICATION/PRE-TREATMENT ABSENT.
   - 350 – BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL

Issues

Is the insurance carrier's denial of payment supported?

Findings

The requestor seeks reimbursement of outpatient surgical procedure rendered on November 14, 2019. The insurance carrier denied the disputed service with denial reduction codes 721 and 197 (definitions above). The requestor indicates that preauthorization was not required as the services were rendered were billed to Aetna, the private insurance company.

28 TAC §134.600 (p) (2) states in pertinent part non-emergency outpatient surgical or ambulatory surgical services require prior authorization.

Review of the documentation submitted by the requestor does not support that preauthorization was obtained for the outpatient surgical procedure. Although the requestor indicates that the disputed services were initially billed to private health, the requestor did not submit sufficient documentation to support the rationale for billing the private health insurance, as the documentation submitted supports that previous dates of services were billed to the correct workers compensation insurance.

The DWC finds that the insurance carrier's denial reason is supported, and that preauthorization was required and not obtained. As a result, reimbursement cannot be recommended for the outpatient services in dispute.

Conclusion

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. For the reasons above the requestor has not established payment is due. As a result, the amount ordered is
$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of TLC §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 24, 2020 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, 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 with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

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