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 HEALTH FORT WORTH

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-21-1147-01

Carrier's Representative
Box Number 54

MDR Received Date
March 8, 2021

Response Submitted by:
Texas Mutual Insurance Company

REQUESTOR'S POSITION SUMMARY

"Attached is a copy of denial, UB04, itemized statement and medical records for your review. Our patient was seen for inpatient services 10/15/2020- 10/18/2020. The claim was submitted to Texas Mutual and denied stating that the services exceeds the authorized length of stay. A reconsideration was submitted asking for the claim to be processed and paid based on the authorized days/charges… Currently the expected reimburse rate is $15,600.51 which 143% x 10,909.45 (expected DRG). The adjuster is not agreeing to pay the balance that owed."

RESPONDENT'S POSITION SUMMARY

"Texas Mutual has reviewed the DWC60 submitted by TEXAS HEALTH FORT WORTH, documentation submitted did not include a copy of the appeal previously submitted by the requestor. Review of the claim file and bill history confirms TEXAS HEALTH FORT WORTH did not submit an appeal to Texas Mutual upon receiving the first denial."

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
October 15, 2020 through October 18, 2020	Inpatient Facility Charges	$27,108.10	$0.00

FINDINGS AND DECISION

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

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-198 – Precertification/authorization exceeded.
   - 711 – Length of stay exceeds number of days previously preauthorized.

Issues

Is the insurance carrier's denial of payment supported?

Findings

The requestor seeks reimbursement in the amount of $27,108.10 for inpatient hospital services rendered October 15, 2020 through October 18, 2020. The insurance carrier denied the disputed services based on lack of pre-authorization.

The requestor states in pertinent part, "The claim was submitted to Texas Mutual and denied stating that the services exceeds the authorized length of stay."

28 TAC 134.600 (p)(1) states, "(1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay…"

Review of the documentation finds that the requestor submitted insufficient evidence to support that preauthorization was obtained for the inpatient facility charges. The DWC finds that the preauthorization was required for the services in dispute pursuant to 28 TAC 134.600 (p)(1). As a result, reimbursement is not recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, therole of DWC 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.

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 DWC has determined that the requestor is not entitled to reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 2, 2021 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed, or personally delivered to the DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR 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 DWC. **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.