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
St Joseph Medical Center

Respondent Name
Sentinel Insurance Company Ltd

MFDR Tracking Number
M4-21-1371-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
April 6, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The purpose of this letter is to inform you that payment for services provided to the above referenced patient does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code."

Amount in Dispute: $639.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Services in dispute were denied as medical reports submitted were not for the date billed."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 20, 2020	Outpatient Hospital Services	$639.85	$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 of prior authorization.
3. The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:
    - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
    - 295 – Service cannot be reviewed without report or invoice, please submit report/invoice as soon as possible to ensure accurate processing

- 483 – Medical report required for payment
- W3 – Additional payment made on appeal/reconsideration.
- 197 – Payment denied/reduced for absence of precertification/authorization

Issues

Is the insurance carrier's denial of payment supported?

Findings

The requestor is seeking reimbursement of outpatient hospital services rendered in August 2020. The insurance carrier denied the original claim for missing information and the reconsideration as lacking prior authorization.

28 TAC §134.600 (p)(2) states in pertinent part that non-emergency health care that requires preauthorization includes outpatient surgical or ambulatory surgical services. Review of the submitted medical bill found the type of bill listed in box four of the CMS UB-04 was 131 which indicates an outpatient facility bill.

Prior authorization was required but insufficient documentation was found to support the disputed service was prior authorized as required by Rule. The insurance carriers' denial is supported. No payment is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role 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 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

Signature	Medical Fee Dispute Resolution Officer	April 26, 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 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 DWC 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 TAC §141.1(d).

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