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 SPINE AND JOINT HOSPITAL

Respondent Name
ZURICH AMERICAN INSURANCE COMPANY

MFDR Tracking Number
M4-21-1517-01

Carrier's Representative
Box Number 19

MDR Received Date
April 29, 2021

Response Submitted by:
Texas Mutual Insurance Company

REQUESTOR'S POSITION SUMMARY

"The Hospital billed Gallagher Bassett, but the bill was denied based on the extent of the compensable injury. We appealed this denial, but the Explanation of Benefits did not include the extent of injury denial. Rather, it stated the bill was denied for a lack of authorization. We have been unable to determine if the extent of injury issue has been resolved, so we are filing this Medical Fee Dispute Resolution Request in the event extent of injury has been resolved and the only denial reason left is related to the authorization. Furthermore, the Hospital does not have any records of a prior MRI being done for this Claimant. Based on these records, this request for authorization was for initial radiology."

RESPONDENT'S POSITION SUMMARY

The Austin carrier representative for Zurich American Insurance Company is Flahive Ogden & Latson. Flahive Ogden & Latson was notified of this medical fee dispute on May 4, 2021. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
April 30, 2020	0610	$6,768.00	$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:
   - 197 – Payment denied/reduced for absence of precertification/authorization.
   - 219 – Based on extent of injury
   - 460 – Based on extent of injury

Issues

1. Is the insurance carrier's denial of extent of injury supported?
2. Is the insurance carrier's preauthorization denial supported?

Findings

1. 28 TAC §133.307(d)(2)(H) further requires that if the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with Rule §124.2 (relating to carrier reporting and notification requirements).

   Review of the submitted information finds no copies, as required by Rule $133.307(d)(2)(H), of any PLN-11 or PLN 1 notices issued in accordance with Rule §124.2. The insurance carrier's denial reason is therefore not supported. Furthermore, because the respondent failed to meet the requirements of Rule §133.307(d)(2)(H) regarding notice of issues of liability, the respondent has waived the right to raise such issues during dispute resolution. Consequently, the division concludes there are no outstanding issues of compensability or liability for the injury. The disputed services are therefore reviewed pursuant to the applicable rules and guidelines.

2. According to the explanation of benefits, the respondent denied reimbursement for outpatient facility charges based upon "197-Precertification/authorization/notification absent."

   The requestor seeks reimbursement in the amount of $6,768.00 for outpatient hospital services rendered April 30, 2020. The insurance carrier denied the disputed services based on lack of pre-authorization.

   The requestor states in pertinent part, "…the bill was denied for a lack of authorization…"

   28 TAC 134.600 (p)(8) states, "(8) unless otherwise specified in this subsection, a repeat individual diagnostic study; (A) with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline…"

   Review of the documentation finds that the requestor submitted insufficient evidence to support that preauthorization was obtained for the outpatient facility charges. The DWC finds that the preauthorization was required for the services in dispute pursuant to 28 TAC 134.600 (p)(8). 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 25, 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.