TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
MEDICAL CENTER OF SOUTHEAST

Respondent Name
XL SPECIALTY INSURANCE COMPANY

MFDR Tracking Number
M4-22-0109-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
SEPTEMBER 20, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 15, 2021 through April 21, 2021	Inpatient Facility charges	$43,976.38	$0.00
	Total	$43,976.38	$0.00

Requestor's Position

"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: $43,976.38

Respondent's Position

"The carrier's second EOB denied the services on the basis of lack of preauthorization. The provider failed to request preauthorization for the procedure (hernia repair) and for the length of stay. The provider was required to request preauthorization in pursuant to Division Rule 134.600(p)(1). In the absence of a request for preauthorization, the carrier is not liable for the services in question. Accordingly, the provider is not entitled to any reimbursement."

Response Submitted by: Flahive, Ogden & Latson

Findings and Decision

Authority

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

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.2 defines emergency.
3. 28 TAC §134.600 sets requirements for prior authorization.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 16 – Claim/service lacks information or ha submission/billing error(s).
- 227 – The report was not included with submitted bill. In order to evaluate and reimburse services, resubmit report with original bill.
- 197 – Precertification/authorization/notification absent.

Issues

1. Is the Insurance Carrier's denial reason(s) supported?
2. Is the Requestor entitled to reimbursement?

Findings

The requestor is seeking reimbursement of $43,976.38 for inpatient hospital services rendered on April 15, 2021 through April 21, 2021. The insurance carrier denied the disputed services based on lack of pre-authorization.

Review of the medical documentation does not document that the services were the result of an emergency and thus pre-authorization was not required. 28 TAC 133.2 defines a medical emergency as the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health or bodily functions in serious jeopardy, or serious dysfunction of any body organ or part.

28 TAC 134.600 (p)(1) states in pertinent part non-emergency health care requiring preauthorization includes Inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay. Insufficient documentation was found to support that pre-authorization was obtained. The DWC finds that the insurance carrier's denial is therefore supported. Reimbursement is therefore not recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that reimbursement of $43,976.38 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to reimbursement for the disputed services.

Authorized Signature

		October 29 2021
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.