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
Providence Memorial Hospital

Respondent Name
Hartford Underwriters Insurance Co

MFDR Tracking Number
M4-22-1579-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
March 29, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 2, 2021	111	3562.00	$0.00
August 2, 2021	300	2621.00	$0.00
August 2, 2021	637	10.00	$0.00
August 2, 2021	636	1361.00	$0.00
August 2, 2021	450	3820.00	$0.00
August 3, 2021	300	2762.00	$0.00
August 3, 2021	730	724.00	$0.00
August 3, 2021	111	3562.00	$0.00
August 3, 2021	250	540.00	$0.00
August 4, 2021	111	3562.00	$0.00
August 4, 2021	360	32023.00	$0.00
August 4, 2021	370	4228.00	$0.00
August 4, 2021	300	1896.00	$0.00
August 4, 2021	320	1470.00	$0.00
August 4, 2021	250	7458.00	$0.00
August 4, 2021	255	570.00	$0.00
August 4, 2021	922	10104.00	$0.00
August 4, 2021	710	5269.00	$0.00
August 5, 2021	250	1399.00	$0.00
August 5, 2021	424	338.00	$0.00

August 5, 2021	111	3562.00	$0.00
August 5, 2021	300	1896.00	$0.00
August 5, 2021	250	256.00	$0.00
August 6, 2021	420	250.00	$0.00
	Total	$10,833.85	$0.00

Requestor's Position

"The Hospital's records reflect the patient was injured in work related injury. The Hospital provided the medically necessary services on the above dates of service. The Hospital billed The Hartford, but the bill was denied. However, despite Hospital's efforts and Request for Reconsideration The Hartford has not rendered proper payment."

Amount in Dispute: $10,833.85

Respondent's Position

"The bill in question was received 9/13/21 and processed 9/24/21 under cn 217093761. It was denied as not approved/authorized. UR deemed not medically necessary."

Response submitted by: The Hartford

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 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.600 sets out the requirements of prior authorization.

Denial Reasons

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

- Auth – payment denied/reduced for absence of, or exceeded, pre-certification/authorization. Pre-authorization was not obtained and treatment was rendered without the approval of treating doctor. If you require additional information regarding this bill decision. Contact the claim handler.

Issues

1. Is the insurance carrier's denial based on lack of authorization supported?

Findings

1. The requestor is seeking reimbursement of inpatient hospital services rendered in August 2021. The insurance carrier denied for lack of prior authorization.

   DWC Rule 28 §134.600 (p) states in pertinent part non-emergency health care requiring prior authorization includes inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay.

   Review of the submitted documentation did not support an emergency or that a prior authorization request was made or received. The insurance carrier's denial is supported. No payment is 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 additional reimbursement is due.

Order

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

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 6, 2022 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.