

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Providence Memorial Hospital

Respondent Name

New Hampshire Insurance Co

MFDR Tracking Number

M4-23-0781-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

December 2, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 4 – 31, 2021	Outpatient Hospital Services	\$9,974.46	\$0.00
Total		\$9,974.46	\$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 Gallagher Bassett, but the bill was denied. However, despite the Hospital's efforts and Request for Reconsideration, Gallagher Bassett has not rendered payment."

Amount in Dispute: \$9,974.46

Respondent's Position

"The provider's explanation appears to be that if it believes that the services are medically necessary, then the provider is not required to receive preauthorization approval prior to the services being rendered. However, that is inconsistent with the Texas insurance code and DWC rule 134.600 (p). While the carrier does not concede that the services were medically necessary, the fact that they may have been medically necessary does not remove the provider's duty to obtain preauthorization approval prior to providing services that require preauthorization.

Accordingly, the provider is not entitled to 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 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 reduced or denied the disputed service(s) with the following claim adjustment codes.

- 31065 – This service was not pre-authorized in conformance with TWCC Rule 134.600

Issues

1. Was prior authorization required for disputed services?

Findings

1. The requestor is seeking payment of outpatient hospital services of laboratory and infusion services rendered from December 4th, 2021, to December 31st, 2021. the insurance carrier denied the medical bill for lack of prior authorization.

DWC Rule 134.600 (p) (2) states in pertinent part, non-emergency health care requiring preauthorization includes outpatient surgical or ambulatory surgical services.

Review of the submitted medical bill found the type of bill “131” or outpatient hospital.

Insufficient evidence was found to support the required prior authorization was obtained. 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

_____	_____	January 5, 2023
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 electrónico CompConnection@tdi.texas.gov.