



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Methodist Health System

Respondent Name

AIU Insurance Co

MFDR Tracking Number

M4-24-2742-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

August 13, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 10, 2023 through October 3, 2023	Inpatient procedure	\$27,826.25	\$0.00
Total		\$27,826.25	\$0.00

Requestor's Position

"DRG 854 (Infectious and Parasitic Diseases with O.R. Procedures with CC) is a MS-DRG and is current per Table 5... length of stay 2023 Final Rule."

Amount in Dispute: \$27,826.25

Respondent's Position

"The inpatient hospital stay was denied preauthorization. On 9/27/202 [sic], Review #6747796 denied as inpatient stay admission. The peer reviewer stated: In this case, the records show that the claimant was appropriately admitted on 9/10/2023 for (redacted) . His stay was appropriate for surgical interventions and (redacted) through 9/17/2023. However, a continue stay in the hospital is not supported based on the records provided. This requested treatment lacks the medical necessity based on provided documentation with the guidelines. Therefore, the request is not certified. Enclosed is a copy of the EOB showing the services were denied for lack of preauthorization for the inpatient hospital stay."

Response submitted by: Downs ♦ Stanford, PC

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 §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.

- 00663 – Reimbursement has been calculated based on the State Guidelines.
- 193/90563 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 31065 – This service was not pre-authorized in conformance with TWCC Rule 134.600.
- 5283 – Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, provider's contract, or carrier decision.
- 16/90084 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Is the insurance carrier's denial supported?

Findings

1. The requestor is seeking reimbursement of an inpatient hospital stay rendered from September to October 2023. The insurance carrier originally denied the claim for lacking information but at the time of reconsideration the services were denied for no prior authorization. Additionally, on September 27, 2024 a UR determination was made that did not certify the inpatient stay based on provided documentation.

DWC will review the disputed charges based on the applicable rule. DWC Rule §28 134.600(p)(1) states, "Non-emergency health care requiring preauthorization includes: (1)

inpatient hospital admissions, including the principal schedule procedure(s) **and the length of stay.**

The submitted documentation presented by the requestor did not support any exception to the requirement of prior authorization or that a request was made to obtain the required authorization for the complete length of the inpatient stay.

As the requirement of prior authorization was not met, the insurance carrier's denial is supported. No reimbursement is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

November 7, 2024
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.