Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Houston Hospital for Specialized Surgery

Respondent Name
Great Midwest Insurance Co

MFDR Tracking Number
M4-14-0098-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 10, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: $9,270.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The provider failed to get preauthorization. Provider forfeited right to reimbursement. Surgery was not of an emergency nature.

Response Submitted By: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 8, 2013	Outpatient Hospital Services	$9,270.10	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 defines words and terms related to medical billing and processing
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Payment adjusted for absence of precert/preauth
   - 193 – Original payment decision is being maintained

Issues

1. Did the requestor support definition of emergency?
2. Was preauthorization required?

Findings

1. The health care provider did not submit a response for consideration in this review. Per the Division's former rule at 28 Texas Administrative Code §133.307(d)(1), effective May 25, 2008, 33 *Texas Register* 3954, "If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information." Accordingly, this decision is based on the available information.

2. 28 Texas Labor Code §133.2(5) states in pertinent part, "(A) a medical emergency is 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: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part;"
   Review of the submitted medical record finds:

   > Operative report; May 8, 2013, "He was previously debrided 48 hours ago for the acute initial osteomyelitis debridement. He returns now for a 48-hour repeat debridement check to be certain there is not additional progressive necrosis as can often be seen with severe infection as he demonstrated…"

   This procedures was scheduled not "sudden onset" as defined by Rule 133.2. Therefore the definition of emergency is not met.

3. 28 Texas Administrative Code §134.600 (p)"Non-emergency health care requiring preauthorization includes (2) outpatient surgical or ambulatory surgical services." Authorization was not requested. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement 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 Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 10, 2014 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 Texas Administrative Code §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 Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division 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 Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.