



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

BAYLOR SURGICAL HOSPITAL

Respondent Name

LUMBERMENS UNDERWRITING ALLIANCE

MFDR Tracking Number

M4-14-2649-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

APRIL 28, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claimant was seen on an emergency basis; therefore your denial for lack of preauthorization is an erroneous denial."

Amount in Dispute: \$8,178.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "One of the bases for the billing dispute is the absence of preauthorization."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 9, 2014	Outpatient Hospitalization Services CPT Code 27822-RT	\$8,295.90	\$0.00
	Other Outpatient Hospitalization Services	(\$117.14)	\$0.00
TOTAL		\$8,178.76	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
- 28 Texas Administrative Code §133.2, effective July 27, 2008, 33 TexReg 5701, defines a medical emergency.
- 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 197-Payment adjusted for absence of precert/preauth.
 - GP-Service delivered under OP PT care plan.
 - RT-Right Side
 - B15-Procedure/Service is not paid separately.

- RN-Not paid under OPSS; services included in APC rate.
- TC-Technical Component
- W1-Workers compensation state fee schedule adj.
- W3-Appeal/Reconsideration

Issues

1. Does the submitted documentation support a medical emergency?
2. Do the disputed X-ray and MRIs require preauthorization? Is the requestor entitled to reimbursement?

Findings

1. The respondent contends that the requestor is not due reimbursement for the disputed services because preauthorization was not obtained.

The requestor states “The claimant was seen on an emergency basis; therefore your denial for lack of preauthorization is an erroneous denial.”

28 Texas Administrative Code §134.600(c)(1)(A), states “The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);

28 Texas Administrative Code §133.2 (3) defines “Emergency--Either a medical or mental health emergency as follows: (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.”

The claimant sustained the compensable injury on January 3, 2014. No documentation was submitted to support services performed were a medical emergency per 28 Texas Administrative Code §133.2 (3); therefore, preauthorization was required for the outpatient hospitalization.

2. The respondent contends that because preauthorization was not obtained for the surgery and hospitalization than all related services are not reimbursable.

28 Texas Administrative Code §134.600(p)(2) states “Non-emergency health care requiring preauthorization includes: (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section.” The requestor did not submit any documentation to support that preauthorization was obtained for the outpatient hospitalization and surgery. As a result, no reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that 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

02/25/2015
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.