



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

Houston Hospital for Specialized Surgery

**Respondent Name**

Travelers Indemnity Co

**MFDR Tracking Number**

M4-15-0876-01

**Carrier's Austin Representative**

Box Number 05

**MFDR Date Received**

November 10, 2014

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "This patient was put as an add on to the schedule per the doctor as an emergency to provide the surgery the same day of service the patient was seen. Therefore, no prior authorization is required for the services."

**Amount in Dispute:** \$15,377.88

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "...Nothing in Dr. Novosad or Dr. Henry's medical records indicate the surgery was necessitated by the emergency nature of the Claimant's condition. The referrals were not made on an emergency basis, and several days elapsed between the office visits prior to surgery. As such, the documentation does not support that this was emergency surgery. Consequently, preauthorization was required for this surgical procedure under Rule 133.600(p). Since preauthorization was not obtained, the Provider is not entitled to reimbursement."

**Response Submitted by:** Travelers

#### SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
April 15, 2014	Outpatient Hospital Services	\$15,377.88	\$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 medical fee disputes.
- 28 Texas Administrative Code §133.2 defines an emergency.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 97 – Pre-auth not obtained prior to svc/proc being rendered

**Issues**

- Does the disputed service(s) meet the definition of emergency service?
- Is the requestor entitled to reimbursement?

**Findings**

1. The insurance carrier denied disputed services with reason code, 97 – “Pre-auth not obtained prior to svc/proc being rendered.” 28 Texas Administrative Code §133.2(4)(A) states that, “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 function in serious jeopardy, or (ii) serious dysfunction of any body organ or part.” The medical documentation does not meet the definition of an emergency pursuant to §133.2(4)(A). For example:
  - a. Operative report - “The patient says she can see her radiographs are severe enough displacement of the fracture that it seems clear to her that it would need to be fixed surgically.”

The Division concludes the denial code 97 is supported as no documentation was found to support a sudden onset of a medical condition nor was any acute symptoms found.

2. Requestor did not support definition of medical emergency.

**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 Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$0.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

Signature	Medical Fee Dispute Resolution Officer	Date
		March 5, 2015

**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.**