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
Dallas County Hospital

Respondent Name
Service Lloyds Insurance Co

MFDR Tracking Number
M4-15-1330-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
January 2, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "While the DWC rule does not have a "prudent layperson" standard, it is still – inevitably – largely a claimant's perception of severity that prompts him/her to seek emergency care. In the present matter, the Claimant was suffering from a recent onset of Patient's presenting concerns. It is reasonable to assume that this led the Claimant to believe that a delay in treatment would put him at risk of "serious dysfunction of any body organ or part."

Amount in Dispute: $564.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…CorVel maintains the requestor has failed to provide clinical evidence that demonstrates the injured employee had a sudden onset of a medical condition manifested by acute symptoms of sufficient severity or sever pain that in the absence of immediate medical attention the injured employee could reasonably expect "serious dysfunction of any body organ or part."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
April 30, 2014	Outpatient Hospital Services	$564.00	$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 an emergency.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent healthcare.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   1.197 – Payment adjusted for absence of precert/preauth

Issues

1. Was prior authorization based on Division rules?

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

Findings

1. The Carrier denied the disputed service as, 197 – "Payment adjusted for absence of precert/preauth." 28 Texas Administrative Code §134.600 (p) states in pertinent part, "Non-emergency health care requiring preauthorization includes:(5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to: (i) Modalities, both supervised and constant attendance; (ii) Therapeutic procedures, excluding work hardening and work conditioning;"
2. 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 meets the definition of an emergency pursuant to §133.2(4)(A). For example:
    a. Therapeutic Interventions – "Therapeutic Exercise, Active ROM, Passive ROM, Strengthening; Stretching."

   The Division concludes the definition of an emergency is not supported by the submitted documentation. Therefore, the disputed services would have required prior authorization. The Carrier's denial is supported.

3. Exception to prior authorization requirement not met. The submitted documentation details therapeutic services not treatment of an emergency. 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

		April 9, 2015
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 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.