



# 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

**Respondent Name**

LM Insurance Corp

**MFDR Tracking Number**

M4-15-2060-01

**Carrier's Austin Representative**

Box Number 01

**MFDR Date Received**

March 9, 2015

#### REQUESTOR'S POSITION SUMMARY

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

**Amount in Dispute:** \$3,397.88

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "We have no record of a request for preauthorization being submitted for the surgery of 9/30/2014 for (claimant)."

**Response Submitted by:** Liberty Mutual

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 30, 2014	Outpatient Hospital Services	\$3,397.88	\$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 §134.600 sets out the guidelines for prospective and concurrent review of health care.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 170 – Pre-authorization was required, but not requested for this service per DWC Rule 134.600
  - 193 – Original payment decision is being maintained

#### **Issues**

- Is the Carrier liable for the services in dispute?
- Is the requestor entitled to reimbursement?

**Findings**

1. The requestor states in their position statement, "The patient was put as an add on to the schedule per the doctor as an emergency to provide the surgery the same ay of service the patient was seen. Therefore, no prior authorization is required for the services." 28 Texas Labor Code §134.600 (c) states in pertinent section, "The insurance 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); (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care;" Review of the submitted medical record finds;

- a. History and Physical Exam from September 30, 2014 – "Primary Symptom: Pain, Severity – Mild"
- b. Swelling: limited

28 Texas Administrative Code §133.2 (5) states, "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;" Based on review of medical documentation the requestor's position is not supported. The Carrier is not liable for the disputed services.

2. Requirements of Rule 134.600 not met, 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	April , 2015 Date
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**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.**