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
M4-15-2082-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
March 10, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In this matter, the Claimant was suffering from a recent onset of Patient's present concerns. It is reasonable to assume that this led the Claimant to believe that a delay in treatment would put him/her 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, Dallas County Hospital District is not entitled to reimbursement for date of service 04/25/14 in the amount of $564.00 for CPT Code 97110 (-GO) based on failure to obtain preauthorization for non-emergency health care in accordance with preauthorization rules set forth under §134.600."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 25, 2014	Occupational Therapy	$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 §134.600 sets out the guidelines for prospective and concurrent review of health care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Payment adjusted for absence of precert/preauth

Issues

1. Is the Carrier liable for the services in dispute?
2. Is the requestor entitled to reimbursement?

Findings

1. The Carrier denied the dispute service as "197 – Payment adjusted for absence of precert/preauth." 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. Therapeutic Interventions, Modalities Paraffin, Therapeutic Exercise, Action ROM; Passive, ROM – Strengthening: Stretching

    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 definition of Emergency is not met nor was prior authorization obtained. The Carrier is not liable.
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

		April 23, 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.