TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Mark H Henry MD

Respondent Name
Electric Insurance Co

MFDR Tracking Number
M4-15-3752-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
July 16, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached medical records adequately support each of the services provided and is sufficient to warrant payment as set forth by the aforementioned section of the Texas Administrative Code. The injured worker's medical condition has been determined to be a medical emergency as defined in the Texas Administrative Code."

Amount in Dispute: $4,457.45

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "On 11/19/14, a physician advisor reviewing the request for preauthorization called Requestor to discuss the preauthorization request. The physician advisor was told "Dr. Henry does not want to discuss the review and to base the determination on the records provided." The physician review opined the surgical procedure was not medically necessary, and a denial of the request for preauthorization was submitted on 11/20/14. Requestor did not file an appeal of the denial of preauthorization. Instead, he chose to perform the procedure on the scheduled date of 12/1/14. The medical bill was properly denied because preauthorization was required and subsequently denied. Requestor now argues the surgery was an emergency. However, the surgery was pre-planned, thereby negating any emergent nature of the procedure."

Response Submitted by: Downs ♦ Stanford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 1, 2014	20680 -58 –F6 x 3, -57 x2, 11042 -RT	$4,457.45	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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. 28 Texas Administrative Code §133.2 defines emergency.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - W3 – Additional payment made on appeal/reconsideration
   - 39 – Services denied at the time authorization/pre-certification was requested
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time
   - 247 – A payment or denial has already been recommended for this service

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Did the submitted documentation meet the definition of emergency as stated by requestor?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 39 – "Services denied at the time authorization/pre-certification was requested." 28 Texas Administrative Code §134.600 (p) states, "Non-emergency health care requiring preauthorization includes: (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section."

   Review of the submitted information finds that on November 20, 2014 the submitted request for prior authorization was reviewed and denied by Network Medical Review Co. The insurance carrier's denial reason is supported.

2. 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;
   >
   > (B) a mental health emergency is a condition that could reasonably be expected to present danger to the person experiencing the mental health condition or another person.

   The submitted medical documentation was not sufficient to support the definition of emergency as stated above. The requestor's statement is not supported.

3. 28 Texas Administrative Code §134.600 (c) states,

   > 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;
   >
   > (C) concurrent utilization review of any health care listed in subsection (q) of this section that was approved prior to providing the health care; or
   >
   > (D) when ordered by the commissioner;

Based on submitted documentation, the Division finds insufficient information to support Rule 134.600(1)(A) or (B) were 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

		August , 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, 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 MFDR 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.