



**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**

MEMORIAL HERMANN HEALTH SYSTEM

**Respondent Name**

TX PUBLIC SCHOOL WC PROJECT

**MFDR Tracking Number**

M4-16-2395-01

**Carrier's Austin Representative**

Box Number 01

**MFDR Date Received**

APRIL 11, 2016

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "The hospital admitted the patient from the emergency room and confirmed with the carrier that the injury was work related and that no pre-authorization was necessary for an ER admit. On [REDACTED] the patient suffered severe burns to his arm and face due to a fire at work which ultimately resulted in this emergency admission. The patient suffered complications from his burns which required surgery, and required follow up care and treatment in the hospital through August 31, 2015 at which time he was discharged."

**Amount in Dispute:** \$29,373.84

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "the assertion that Respondent advised Reqeustor that preauthorization was not necessary for admission to the hospital is unsubstantiated and untrue. Based on the applicable law, Requestor was required to seek preauthorization for the services in question in accordance with Division Rule 134.600(p). However, the credible evidence reflects that Requestor never submitted a preauthorization request for the inpatient hospitalization and surgical services in question. Consequently, in the absence of any credible evidence that Requestor sought preauthorization for the services in question, it is not entitled to reimbursement from Respondent."

**Response Submitted by:** Creative Risk Funding

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 24, 2015 through August 31, 2015	Inpatient Hospital Services	\$29,373.84	\$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, effective July 1, 2012, requires preauthorization for specific treatments and services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
- 197-Payment denied/reduced for absence of precertification/authorization.
  - 15-The authorization number is missing, invalid, or does not apply to the billed services or provider.
  - 150-Payer deems the information submitted does not support this level of service.
  - 29-The time limit for filing has expired.
  - W3.

### Issues

Does a preauthorization issue exist? Is the requestor entitled to reimbursement?

### Findings

According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon a lack of preauthorization.

28 Texas Administrative Code §134.600(c)(1)(A) 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)."

28 Texas Administrative Code §134.600(p)(1) requires preauthorization for "inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay."

28 Texas Administrative Code §134.600(q)(1) states "The health care requiring concurrent utilization review for an extension for previously approved services includes: inpatient length of stay."

28 Texas Administrative Code §133.2(5)(A)(i)(ii) 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."

The requestor states "On August 24, 2015, the patient suffered severe burns to his arm and face due to a fire at work which ultimately resulted in this emergency admission. The patient suffered complications from his burns which required surgery, and required follow up care and treatment in the hospital through August 31, 2015 at which time he was discharged."

The requestor failed to submit any medical records to support the assertion that the disputed services were rendered on an emergency basis per 28 Texas Administrative Code §133.2(5)(A)(i)(ii), nor a preauthorization approval reports for the disputed services; therefore, a preauthorization issue exists and reimbursement is not 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

05/13/2016  
\_\_\_\_\_  
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.**