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
UT Physicians

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-17-3400-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 21, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is our opinion that the bill should be covered due to patient's inpatient status and medical necessity for procedures."

Amount in Dispute: $10,094.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of review."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 24, 2016	Inpatient Hospital Services	$10,094.00	$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 §133.20 sets out definition of emergency.
3. 28 Texas Administrative Code §134.600 sets out the requirements for prior authorization.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Precertification/authorization/notification absent
   - W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

Issues

1. Did American Zurich Insurance Co respond to the medical fee dispute?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. The Austin carrier representative for American Zurich Insurance Co is Flahive, Ogden & Latson. Flahive, Ogden & Latson acknowledged receipt of the copy of this medical fee dispute on July 31, 2017.

   28 Texas Administrative Code §133.307 (d) (1) states, in relevant part:

   > Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
   >
   > (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile **within 14 calendar days after the date the respondent received the copy of the requestor's dispute** [emphasis added]. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

   Review of the documentation finds that no response has been received on behalf of American Zurich Insurance Co from Flahive, Ogden & Latson to date. The division concludes that American Zurich Insurance Co failed to respond within the timeframe required by §133.307(d)(1). For that reason the division will base its decision on the information available.

2. The requestor is seeking reimbursement for inpatient hospital services in the amount of $10,094.00 rendered on October 24, 2017. The insurance carrier denied disputed services with claim adjustment reason code 197 – "Precertification/authorization/notification absent."

   28 Texas Administrative Code §134.600 (p) states in pertinent part,

   > (p) Non-emergency health care requiring preauthorization includes:
   >
   > (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay

   Review of the submitted "Consultation" dated October 21, 2016, page 1 found:

   > "Upon presentation to MHH ED, imaging revealed bilateral femur fractures and a R calcaneus fracture."

   Review of the submitted "Operative Report" dated October 24, 2016 page 2 finds

   > "…has consented for operative management of the left distal femoral comminuted supracondylar intercondylar fracture."

   28 Texas Administrative Code 133.2 (5) (A) 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;

   After review of the submitted documentation, the Division finds a medical emergency did occur on October 21, 2016. However, as the date of service in dispute is October 24, 2016, three days later, the definition of "medical emergency" was not met. Therefore, prior authorization was required. Insufficient evidence was found to support the health care provider requested prior authorization. The carrier's denial is supported. No additional payment is 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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		January 18, 2018
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 Rule §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 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. **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.