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
St. Joseph Medical Center

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-20-0076-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 12, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: $5,166.65

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…Per rule 134.600 if it is not an emergency bill charges require per auth."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 7, 2019	Outpatient Hospital Services	$5,166.65	$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 §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. 28 Texas Administrative Code §133. 2 defines medical emergency
4. 28 Texas Administrative Code §134.600 sets outs requirements for prior authorization
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Precertification/authorization/notification/pre-treatment absent
   - 193 – Original payment decision is being maintained

Issues

1. Is the respondent's position supported?

Findings

1. The respondent states in their position, "Per rule 134.600 if it is not an emergency bill charges require pre auth."

   Review of the submitted record finds, "Office visit note dated 05/06/2019 indicates a diagnosis of [redacted] Splinting: Hand: Left Side Alumifoam index Splint Left Side Alumifoam Ring Splint. To be immobilized by splint. This record shows the patient was seen at 12:45 pm.

   Review of the St Joseph Medical Center Encounter Information found the Admit Type: "Elective" on May 7, 2019 at 16:00 (4:00 pm).

   Review of the Anesthesia Record Pain assessment: "Self-reports no pain" on May 7, 2019.

   Rule §133.2 defines emergency as 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 placing the patient's health or bodily functions in serious jeopardy, or serious dysfunction of any body organ or part.

   Based on the submitted records, the injury occurred on [redacted].

   At the time of the office visit on May 6, 2019 the claimant reported pain and some swelling but the next day reported no pain.

   The surgery was considered "elective" thus the definition of Rule §133.2 is not met and insufficient evidence was found the health care provider made any attempt to obtain authorization.

   The insurance carriers' denial is upheld. No additional payment is recommended.

Conclusion

For the reasons stated above, DWC 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, DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 18, 2019 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.