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
Harris County

MFDR Tracking Number
M4-20-0198-01

Carrier's Austin Representative
Box Number 21

MFDR Date Received
September 23, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: None submitted

Amount in Dispute: $5,166.65

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent urges that the matter be dismissed from Medical Fee Dispute Resolution, as the request was not complete. In the alternative, Respondent requests that no reimbursement be ordered as the services were not preauthorized in accordance with the applicable rules."

Response Submitted by: Thornton Biechlin Reynolds & Guerra

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 13, 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 §134.600 sets out the requirements for prior authorization.
3. 28 Texas Administrative Code §133.20 defines emergency.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Payment denied/reduced for absence of precertification/authorization
   - W3 - Reconsideration

Issues

Is the insurance carrier's reason for denial supported?

Findings

The requestor is seeking reimbursement outpatient hospital services rendered June 13, 2019 in the amount of $5,166.65.

The insurance carrier denied the disputed services based on lack of preauthorization.

28 TAC §134.600 (p) states that non-emergency health care that requires preauthorization includes outpatient surgical services.

The respondent states, "The records do not establish that the procedure was an emergency."

28 TAC §133.20 defines emergency as 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.

Review of the submitted medical record finds the date of injury was [redacted]. The patient was seen on June 4, 2019. Surgery was performed on June 13, 2019.

Based on the above the definition of emergency is not met.

Insufficient evidence was found to support an authorization was obtained or an attempt to receive authorization was done.

The respondent's position and denial are supported.

Conclusion

In resolving dispute over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings of this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above, the requestor has not established payment is due. 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	November 7, 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.