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
Worth Casualty Co

MFDR Tracking Number
M4-20-0310-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
October 2, 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: "Salus determined that St. Joseph medical Center did not obtain pre-authorization for services rendered. Therefore, no allowance is being recommended."

Response Submitted by: Salus Claims Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 25, 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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - 197 – Payment adjusted for absence of precert/preauth

Issues

Is the insurance carrier's reason for denial supported?

Findings

The requestor is seeking reimbursement for outpatient hospital services rendered on January 25, 2019.

The insurance carrier denied the services based on lack of pre-authorization.

28 TAC §134.600 (p) outlines the services that which require pre-authorization that include non-emergency outpatient surgical services.

28 TAC 133.2 (5) defines a medical 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 found;

- The onset of the injury was [redacted].
- An office visit was done on January 22, 2019 at 12:00 pm that recommended the surgery.
- The admission type was elective on January 25, 2019 or three days after being seen by the physician recommending surgery.

Insufficient evidence was found to support an exception based on an emergency to the requirement for prior authorization.

No evidence was submitted that the health care provider obtained or made any attempt to obtain prior authorization.

The insurance carrier's denial is upheld.

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

		October 23, 2019
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 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.