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
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-20-2074-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
Aril 30, 2020

Response Submitted by:
Liberty Insurance Corp

REQUESTOR'S POSITION SUMMARY

"…this was aa emergent visit. Therefore, per TX fee schedule no authorization was not needed."

RESPONDENT'S POSITION SUMMARY

"We base our payments on the Texas Fee Guidelines and the Texas Department of Insurance Division of Workers' Compensation Acts and Rules. This is not a network claim. We reviewed this dispute and cannot find an open claim for [injured employee]. Per the attached document, it appears the correct carrier is Sedgwick CMS. Please send the dispute to the correct carrier for review and handling."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 17, 2020	Outpatient Hospital Services	$3,249.70	$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 §133.2 defines emergency
3. 28 Texas Administrative Code §134.600 sets requirements for prior authorization.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 5264 – Payment is denied-service not authorized
   - 197 – Payment denied/reduced for absence of precertification/authorization
   - W3 – Additional payment made on appeal/reconsideration

Issues

Is the insurance carrier's denial of payment supported?

Findings

The requestor is seeking reimbursement of $3,249.70 for outpatient hospital services rendered March 17, 2020. The insurance carrier denied the disputed services based on lack of pre-authorization. The requestor states, "…this was aa emergent visit. Therefore, per TX fee schedule no authorization was not needed."

28 TAC §133.2 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.

The DWC finds that review of the information contained in the dispute was insufficient to support the definition of a medical emergency as defined per 28 TAC §133.2 Based on this review, the definition of emergency is not met. The requestor's position is therefore not supported, and preauthorization was required pursuant to 28 TAC §134.600 (p)(2).

28 TAC §134.600 (p)(2) states in pertinent part non-emergency health care requiring preauthorization includes outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section. Insufficient documentation was submitted to identify that pre-authorization was obtained. The DWC finds that the insurance carrier's denial is supported and as a result, additional payment cannot be recommended.

For the reasons indicated above, the requestor has not established that payment is due. As a result, the amount ordered is $0.00.

Conclusion

In resolving disputes 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 in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

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

Signature	Medical Fee Dispute Resolution Officer	August 21, 2020 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.