



# 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**

ACIG

**MFDR Tracking Number**

M4-20-2111-01

**Carrier's Austin Representative**

Box Number 47

**MFDR Date Received**

April 30, 2020

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Per page 25 of the Medical Records, this was a medical emergency as classified by the State of fee schedule."

**Amount in Dispute:** \$5,482.02

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "...the evidence shows the procedure was not emergent. The surgery was not recommended until seven days after the injury. It was depicted as "elective." The surgery was performed three days after being recommended, eleven days after the injury. St Joseph clearly had time to obtain preauthorization. It failed to do so."

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 16, 2020	Outpatient Hospital Services	\$5,482.02	\$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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.2 defines emergency.
- 28 Texas Administrative Code §134.600 sets out requirements of prior authorization.
- 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 denial of payment supported?

**Findings**

The requestor is seeking reimbursement of \$5,482.02 for outpatient hospital services rendered January 16, 2020. The insurance carrier denied for lack of preauthorization, the requestor states services were necessary due to an emergency.

Review of the submitted medical record, the patient was seen in the physician’s office on January 13, 2020. Surgery was schedule and preformed on January 16, 2020.

28 TAC §133.2 states in pertinent part, 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.

As the surgery was performed three days after the office visit, the definition of emergency is not supported.

28 TAC 134.600 (p)(2) states, non-emergency health care requiring preauthorization includes outpatient surgical or ambulatory surgical services. The insurance carrier’s denial for lack of preauthorization is supported.

**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.

For the reasons above the requestor has not established payment 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**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
June 5, 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.**