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
Incline Casualty Co

MFDR Tracking Number
M4-20-2464-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
June 8, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per page 61 of the medical records (attached), this was an emergent visit. Therefore, authorization is not needed."

Amount in Dispute: $4,643.81

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Austin carrier representative for Incline Casualty Co is JT Parker & Associates LLC who was notified of this medical fee dispute on June 16, 2020. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information

As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 20, 2020	Outpatient Hospital Services	$4,643.81	$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 of prior authorization.
3. 28 Texas Administrative Code §133.2 defines emergency.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 15 – Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
   - 293 – This procedure requires prior authorization and none was identified

Issues

Is the insurance carrier's denial of payment supported?

Findings

The requestor is seeking reimbursement of $4,643.81 for outpatient hospital services rendered January 20, 2020. The insurance carrier denied the disputed services for lack of preauthorization. The health care provider indicates the services were required due to an emergency.

28 TAC §133.2 (5) (A) states in pertinent part an 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.

Review of the submitted medical record found the patient was seen in the physician's office on January 17, 2020. The disputed surgery was performed on January 20, 2020. Based on this review the definition of emergency was not met.

28 TAC §134.600 (p)(2) states in pertinent part non-emergency health care requiring preauthorization includes outpatient surgical or ambulatory surgical services. Insufficient evidence was found to support the required pre-authorization was obtained.

The insurance carrier's denial for lack of pre-authorization is supported. No payment is recommended.

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	August 28, 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.