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
Texas Mutual Insurance Co

MFDR Tracking Number
M4-20-2807-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
July 29, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per page 77 of medical records, this was a medical emergency. Authorization is not needed."

Amount in Dispute: $998.33

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual Insurance argues if the surgery was truly emergent, then options would not have been given to the patient to return in a week."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 7, 2020	Outpatient Hospital Services	$995.33	$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 set out requirements of prior authorization.
4. The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:
    - P12 – Workers' compensation jurisdictional fee schedule adjustment
    - 197 – Precertification/authorization/notification absent

Issues

Is the insurance carrier's denial of payment supported?

Findings

The requestor is seeking reimbursement of $995.33 for outpatient hospital services rendered May 7, 2020. The insurance carrier denied the service for lack of pre-authorization.

28 TAC §134.600 (p)(2) states in pertinent part non-emergency outpatient surgical services requires pre-authorization. The requestor states, "this was a medical emergency." Review of the submitted medical record of the May 7, 2020 physician office visit shows this visit to be subsequent to a May 4, 2020 visit where the same condition was treated.

28 TAC §133.2 define a medical emergency as a sudden onset of a medical condition manifested by acute symptoms. Based on the submitted records, the definition of emergency was not met. The insurance carrier's denial 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	[redacted] 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.