



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

M4-20-2808-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

July 29, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per page 31 of the MRs, this was a medical emergency. Therefore, authorization isn't needed."

Amount in Dispute: \$3,249.70

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual has no record of receiving a preauthorization request for the surgery nor has the requester provided any documentation it sought and attempted to obtain preauthorization."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 14, 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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.2 defines a medical 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:
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
 - 197 – Precertification/authorization/notification absent

- 786 – Denied for lack of preauthorization or preauthorization or preauthorization denial in accordance with the network contract.

Issues

Is the insurance carrier’s denial of payment supported?

Findings

The requestor is seeking reimbursement of outpatient hospital services rendered on May 14, 2020. The requestor states in their reconsideration, “this was a medical emergency. Therefore, authorization isn’t needed.”

Review of the submitted medical record found the injured worker was seen in the physician’s office several times for the same condition prior to the date of service in dispute. Specifically, on May 12, 2020 the patient was seen in the physician’s office. The outpatient procedure was not preformed until May 14, 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. This two-day lag between the physician recommending the outpatient procedure and the procedure being performed does not meet the definition of emergency.

28 TAC 134.600 (p) states in pertinent part non-emergency outpatient surgery requires prior authorization. As no prior authorization was obtained. The insurance carrier’s denial is supported.

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

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.