TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
St Joseph Medical Center

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-21-0054-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
September 11, 2020

Response Submitted by:
Texas Mutual Insurance Company

REQUESTOR'S POSITION SUMMARY

"This was an emergent service; therefore, preauthorization was not required per the TX fee schedule."

RESPONDENT'S POSITION SUMMARY

"Documentation from the surgeon's clinic note Dr. Mark Henry indicate treatment options selected by the patient… Dr. Henry felt the patient should feel free to choose either one (option). The patient chose to have it fixed surgically, however the documentation does not support emergent care. In emergency treatment, Texas Mutual argues that options would not have been given to the patient regarding surgical and non-surgical management options. The patient can choose the surgical option; however, it was the providers responsibility to obtain preauthorization."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 26, 2020 through June 27, 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

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 out requirements of prior authorization.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 786 – DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN ACCORDANCE WITH THE NETWORK CONTRACT
   - CAC-197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT
   - CAC-P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 899 – DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2
   - CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

Issues

Is the insurance carrier's denial of payment supported?

Findings

The requestor seeks reimbursement of outpatient hospital services rendered on June 26, 2020 through June 27, 2020. The insurance carrier denied the disputed service with denial reduction codes 786 and 197 (definitions above). The requestor indicates that preauthorization was not required as the services were rendered in an emergent situation.

28 TAC §134.600 (p) (2) states in pertinent part non-emergency outpatient surgical or ambulatory surgical services require prior authorization.

28 TAC §133.2 defines an 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.

Review of the Anesthesia Record dated June 26, 2020 the patient self-reported no pain onset was on [date of injury]. Based on these notes, the onset was sudden, however the patient reported no pain. The requestor did not submit sufficient documentation to support that the definition of emergency was met. The DWC finds that the insurance carrier's denial reason is supported, and that preauthorization was required and not obtained. As a result, reimbursement cannot be recommended for the outpatient services in dispute.

Conclusion

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 upon the documentation submitted by the parties and in accordance with the provisions of TLC §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 23, 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 28 TAC §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 the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed, or personally delivered to the Division 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 with the Division. **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.