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

MFDR Tracking Number
M4-21-0067-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
September 14, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per page 28 of the medical records, this was a medical emergency. Therefore, authorization isn't needed."

Amount in Dispute: $2,714.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual argues that the procedure of the stage debridement, and the mild severity that is confirmed by the Surgeon on the documentation does not meet the criteria of the emergency rule… Absent an emergency, the facility did not obtain preauthorization for services render per Rule 134.600."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 22, 2020	Outpatient Hospital Services	$2,714.30	$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:
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
   - 197 – Precertification/authorization/notification absent

- 786 – Denied for lack of preauthorization or preauthorization denial in accordance with the network contract
- 899 – Documentation and file review does not support an emergency in accordance with Rule 133.2
- 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 is seeking reimbursement of outpatient hospital services rendered June 22, 2020. The insurance carrier denied the disputed service as requirement of prior authorization not met. The requestor states prior authorization was not required as the services were rendered due to 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 submitted medical record found on the Office Visit of June 22, 2020 at nine in the morning the patient reported mild pain and the onset was May 29, 2020. Based on these notes, the onset was not sudden and the symptoms were mild. The insurance carrier's denial is supported as the definition of emergency was not met and prior authorization was required but not obtained. 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	October 15, 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.