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
Travelers Indemnity Company

MFDR Tracking Number
M4-21-0300-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
October 20, 2020

Response Submitted by:
Travelers

REQUESTOR'S POSITION SUMMARY

"…this was a medical emergency. Therefore, authorization wasn't needed. Please reprocess."

RESPONDENT'S POSITION SUMMARY

"Neither the surgeon nor the Provider requested or obtained preauthorization during this window of time. As the Provider did not have preauthorization prior to performing the disputed surgical services, they are not entitled to reimbursement. The Carrier contends the Provider is not entitled to additional reimbursement."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 1, 2020	Revenue Code 250-710	$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 requirements for prior authorization.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 293 – THIS PROCEDURE REQUIRES PRIOR AUTHORIZATION AND NONE WAS IDENTIFIED.
   - 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWANCE.
   - 15 – PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION

Issue(s)

Is the insurance carrier's denial of payment supported?

Findings

The requestor seeks reimbursement of $5,482.02 for outpatient hospital services rendered June 1, 2020. The insurance carrier denied the disputed services based on lack of pre-authorization.

The requestor states the disputed services were the result of an emergency and therefore pre-authorization was not required. 28 TAC §133.2 defines a medical 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 documentation finds the following:

- Surgery Scheduling Form, page 3, dated May 15, 2020 noted under Comments: " timing for case based on patient stated need to notify work (would otherwise proceed sooner) he is going to work to move up date if at all possible."
- St Joseph Medical Center Encounter Information dated, June 1, 2020, found the Admit Type: "Elective"
- Anesthesia Record Pain Assessment dated, June 1, 2020, found: "Self-reports no pain."

The DWCC finds that the requestor submitted insufficient documentation to support that the scheduled procedure met the definition of 28 TAC §133.2.

Per 28 TAC §134.600 (p)(2) "…non-emergency health care requiring preauthorization includes outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section." The DWC finds that the requestor submitted Insufficient documentation to support that preauthorization was obtained for the scheduled procedure. As a result, reimbursement cannot be recommended for the services in dispute.

Conclusion

In resolving disputes over reimbursement, 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 indicated 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

______________________	______________________	November 17, 2020
Signature	Medical Fee Dispute Resolution Officer	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, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed, or personally delivered to the 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 with the DWC. **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