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
HAND & WRIST CENTER OF HOUSTON

Respondent Name
ZENITH INSURANCE COMPANY

MFDR Tracking Number
M4-21-0508-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
November 23, 2020

Response Submitted By:
The Zenith

REQUESTOR'S POSITION SUMMARY

"The healthcare provider's position on this claim is that this date of service has been partially denied. We find that one of the charges on this claim has not been paid at 100% of the statutory fee as required by law per Texas Administrative Code Title 28 Part 2 Chapter 134 Subchapter C Rule 134.202. The attached medical records adequately support each of the services provided and is sufficient to warrant payment as set forth by the aforementioned section of the Texas Administrative Code. The injured worker's medical condition has been determined to be a medical emergency as defined in the Texas Administrative Code."

RESPONDENT'S POSITION SUMMARY

"The Claims Examiner has confirmed that the services in dispute were not authorized as required pursuant to 28 Texas Administrative Code § 134.600. Therefore, no payment is due to the provider. Please see Exhibit # 1, Exhibit #2, Exhibit #3, Exhibit #4 and Exhibit #5."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
February 21, 2020	26546, 20680, 20680 x 5 and 73130	$8,167.02	$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 §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §133.2 defines words and terms related to medical billing.
4. 28 Texas Administrative Code §134.600 sets out rules regarding preauthorization of health care.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 224 – Tx Duplicate Charge
   - 18 – Exact duplicate claim/service
   - 932 – Not authorized for service per utilization recommendation
   - 197 – Precertification/authorization/notification/pre-treatment absent

Issues

1. Was preauthorization required?
2. What is the recommended payment for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes 197 and 932 (descriptions provided above.)

   The insurance carrier's response asserts, "There is no indication by Dr. Henry that this surgery was emergent. The ONLY comment on a "medical emergency" is seen in the preauthorization request submitted by Dr. Henry's surgery scheduler, but this is merely a definition of what constitutes an emergency surgery, otherwise completely lacking clinical correlation to the request."

   The division's preauthorization rule, 28 Texas Administrative Code §134.600(p)(2) states that non-emergency health care requiring preauthorization includes: "outpatient surgical or ambulatory surgical service."

   28 Texas Administrative Code §134.600(c)(1)(A) requires that an insurance carrier be liable for all reasonable and necessary health care in an emergency, as defined in 28 Texas Administrative Code Chapter 133.

   28 Texas Administrative Code §133.2(5)(A) 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: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part."

   The division notes the definition does not require the patient to actually *be* in jeopardy or *suffer* serious dysfunction. Rather, the patient must manifest acute *symptoms* of such severity (including severe pain) that the absence of immediate medical attention could *be expected* (prior to rendering services and without the benefit of hindsight) to result in serious jeopardy or dysfunction if treatment is not provided.

   The disputed services are outpatient surgical procedures. The submitted records do not document a medical emergency per 28 TAC §133.2(5)(A). Accordingly, preauthorization was required and not obtained. The DWC therefore finds, that the carrier's denial reasons are supported.

2. The DWC finds, that 28 TAC §134.600(c)(1) requires insurance carriers to be liable for the cost of non-emergency health care only when "preauthorization of any health care listed in subsection (p) … was approved prior to providing the health care."

   In summary of the findings above, a medical emergency was not supported; preauthorization was therefore required to perform outpatient surgery, but not obtained for the disputed services. Consequently, the insurance carrier is not liable for payment. Reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that reimbursement 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

		January 14, 2021
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, 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 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 MDR 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.