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
Baylor Scott & White Temple

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-21-1231-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
March 19, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "(Injured worker) has been without proper treatment and surgery he needed for one week. Due to the extenuating circumstances, (injured worker's) outpatient services were urgent, appropriate and medical necessary according to his condition. There was no time to obtain a prior authorization for this provider."

Amount in Dispute: $9,619.57

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In review of the charges billed it was determined that the surgery performed was not in conjunction with an emergency admission and determined as non-emergency health care."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 19, 2020	Outpatient Hospital Services	$9,619.57	$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 §134.600 sets out the requirements of prior authorization.
3. 28 Texas Administrative Code §133.2 defines an emergency.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Payment denied/reduced for absence of precertification/authorization.

Issues

Is the insurance carrier's denial of payment supported?

Findings

The requestor is seeking reimbursement of outpatient hospital services rendered on June 19, 2020. The insurance carrier denied the disputed service as services lacked authorization.

28 TAC §134.600 (p)(2) states in pertinent part that non-emergency health that includes outpatient surgical services requires prior authorization.

28 Texas Administrative Code §133.2 (5) states a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including sever pain, that the absence of immediate medical attention could reasonable by expected to result in placing the patient's health or bodily functions in serious jeopardy. Review of the submitted documentation found the injured worker was seen initially in the physician's office of June 17, 2020 where a CT scan confirmed the injured worker's condition. The outpatient procedure was performed on June 19, 2020. The two-day lag between when the patient was diagnosed and the procedure being performed does not support the definition of an emergency as described in the above rule.

Prior authorization was required but not obtained. The insurance carrier's denial is supported. 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

		April 16, 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 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.