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
Scott and White Clinic

Respondent Name
Texas Public School WC Project

MFDR Tracking Number
M4-21-1566-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
May 5, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "BSWH believes in this case that CRF made the error or applying the laws and regulations listed under the section 28 Tex. Admin Code § 134.600(c)(1)(B) when denying this claim. BSWH is entitled to reimbursement for the services provided to (claimant) because this was a work related injury."

Amount in Dispute: $6,919.22

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The medical documentation submitted by Scott & White reflects that Claimant was diagnosed with an (redacted) after undergoing a CT scan on May 20, 2020. However, surgery was not performed until May 26, 2020. This six-day lag between diagnosis and surgery does not support the definition of "emergency" as described in the above rule."

Response Submitted by: Creative Risk Funding

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 26, 2020	Inpatient Hospital Services	$6,919.22	$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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

- 197 – Payment denied/reduced for absence of precertification/authorization

Issues

Is the insurance carriers' denial of payment supported?

Findings

The requestor is seeking reimbursement of medical services rendered May 26, 2020. The insurance carrier denied the disputed service for lack of prior authorization.

28 TAC §134.600 (p) states in pertinent part non-emergency health care that requires preauthorization includes inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay.

Review of the submitted documentation found the claimant was seen in the emergency department of Baylor Scott & White Medical Center on May 20, 2020. Insufficient evidence was found the requestor attempted or received prior authorization prior to scheduled surgery date of May 26, 2020.

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

		June 17, 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.