Division of Workers' Compensation

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Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name
St Joseph Medical Center

Respondent Name
Association Casualty Insurance Co

MFDR Tracking Number
M4-21-2042-01

Carrier's Austin Representative
Box Number 53

MFDR Date Received
July 12, 2021

Requester's Position

Preauthorization was not obtained due to injury sustained by patient was emergent in nature. In TX, preauthorization is not required if medical condition is emergent in nature.

Amount in Dispute: $11,727.53

Respondent's Position

This provider did provide services to the Claimant on 3-15-2021 which were for an emergency and thus did not require pre-authorization; however, there was no emergency, as defined by 28 TAC 133.2(5) on 04-12-2021 and therefore the services provided required pre-authorization.

Response Submitted by: Hoffman Kelley Lopez LLP

Summary of Findings

Date of Service	Disputed Services	Amount in Dispute	Amount Due
April 12, 2021	Outpatient Hospital Services	$11,727.53	$0.00
	Total	$11,727.53	$0.00

Findings and Decision

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §133.2 defines emergency.

3. 28 TAC §134.600 sets out requirements of prior authorization

4. The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:
   - U01 – There was no UR procedure/treatment request received.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Did the disputed services meet the definition of an emergency?

2. Was prior authorization required?

Findings

1. DWC Rule 28 TAC 133.2(5)(A) states in pertinent part, a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health or bodily function is serious jeopardy.

   Review of the submitted medical records found documentation of an injury in ████ ███ On April 12, 2021, the injured worker was seen in the physician's office and the suggested treatment was to debride the wound and remove the pin surgically.

   A medical review done by Review Med on July 30, 2021, found the services on April 12, 2021, were not emergent in nature.

2. DWC Rule TAC 134.600(p)(2) states, non-emergency health care requiring preauthorization includes outpatient surgical or ambulatory surgical services.

   The disputed services did require prior authorization but was not requested. 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. Although all the evidence in this dispute may not have been discussed, it was considered.

DWC finds the requester has not established that payment is due. As a result, the amount ordered is $0.

Order

Under Texas Labor Code §413.031, it is ordered that the requester is entitled to $0 additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August , 2021 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252- 7031, Option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed 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.