TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
St Joseph Medical Center

Respondent Name
ACIG Insurance Co

MFDR Tracking Number
M4-22-0094-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
September 20, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 16, 2021	Rev Codes 250-710	$3,433.05	$0.00
	Total	$3,443.05	$0.00

Requestor's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration that states, "Per pg. 45 of the MR, authorization was not obtained due to patient's medical injury was considered a medical emergency. Per TX fee schedule, prior authorization is not required if the medical injury is emergent in nature."

Amount in Dispute: $3,433.05

Respondent's Position

St. Joseph has the burden to establish the services rendered on April 16, 2021, was a medical emergency. St. Joseph has failed to meet its burden. The claimant's condition was not severe, as he reported mild symptoms and no pain. The absence of the service did not place the claimant's health in serious jeopardy, as this was an outpatient procedure and St. Joseph had fourteen days to request preauthorization. Accordingly, ACIG is not liable for reimbursement.

Response submitted by: Burns Anderson Jury & Brenner

Findings and Decision

Authority

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).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.600 sets out the requirements for prior authorization of outpatient pharmacy services.

3. 28 TAC §133.2 defines emergency.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- T197 – Payment denied/reduced for absence of, or exceeded, pre-certification and/or authorization

Issues

1. Is the requestor's position supported?

2. Is the insurance carrier's denial based on lack of authorization supported?

Findings

1. The requestor is seeking reimbursement of outpatient hospital services rendered in April 2021. Their request for reconsideration states, "Per pg. 45 of the MR, authorization was not obtained due to patient's medical injury was considered a medical emergency. Per TX fee schedule, prior authorization is not required if the medical injury is emergent nature.

   DWC Rule 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, including severe pain, that the absence of immediate medical attention could reasonable be expected to result in placing the patient's health or bodily functions in serious jeopardy.

   Review of the submitted documentation found the patient was seen April 2, 2021, after a work-related injury in March. The treating physician notes states "no pain." The disputed outpatient surgery was preformed on April 16, 2021.

   Based on the above information the onset of the condition was not sudden or were acute symptoms present. The requestor's position is not supported as the definition of an emergency per DWC Rule 134.2 is not met.

2. The insurance carrier denied the disputed service for lack of prior authorization. DWC Rule 28 134.600 (p) (2) states in pertinent part non-emergency health care requiring preauthorization includes outpatient surgical services. Prior authorization was required but not obtained. The insurance carrier's denial is supported no additional payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 22, 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 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.