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
FEDERAL INSURANCE COMPANY

MFDR Tracking Number
M4-22-0123-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
September 22, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 5, 2021	Outpatient Facility Charges	$1,049.05	$0.00
	Total	$1,049.05	$0.00

Requestor's Position

"336 - DOS Not Paid. Please see attached itemized statement."

Amount in Dispute: $1,049.05

Respondent's Position

"CorVel maintains the requestor, St. Joseph Medical Center is not entitled to reimbursement for REV code(s) 250-710 in the amount of $1,049.05 for, date of service 04/05/21 based on failure to obtain preauthorization for non-emergency health care in accordance with preauthorization rules set forth under §134.600(p)(2)."

Response Submitted by: CorVel

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 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.2 defines medical emergency.
3. 28 TAC §134.600 sets out the guidelines for preauthorization, concurrent utilization review, and voluntary certification of health care.

Denial Reasons

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

- 197 – Payment adjusted for absence of preauthorization
- RN – Not paid under OPPS: services included in APC rate
- P14 – Payment is included in another svc/procedure occurring on same day
- 234 – This procedure is not paid separately
- W3 – Appeal/reconsideration

Issues

1. Did the requestor meet the definition of medical emergency?
2. Is the Requestor entitled to reimbursement for the outpatient facility charges?

Findings

1. The requestor states the disputed services were a result of an emergent situation. 28 TAC §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 placing the patient's health or bodily functions in serious jeopardy, or serious dysfunction of any body organ or part.

   The requestor submitted insufficient documentation to support their argument that the services rendered were a medical emergency as defined by 28 TAC §133.2. As a result, the submitted medical records do not met the definition of emergency and the dispute is not eligible for review.

2. The requestor seeks reimbursement for outpatient facility charges rendered on April 5, 2021. 28 TAC §134.600 states in pertinent part, (p) non-emergency health care requiring preauthorization includes... (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section."

   Review of the documentation submitted by the requestor does not support that preauthorization was sought for the services in dispute, as a result, reimbursement cannot be 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 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 14, 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.