TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
MHHS The Woodlands Hospital

Respondent Name
XL Insurance America Inc

MFDR Tracking Number
M4-22-0277-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
October 12, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 31, 2021	X-Ray	$974.00	$0.00
July 31, 2021	ER Visit	$3,010.50	$0.00
	Total	$3,984.50	$0.00

Requestor's Position

...the bill is denied for no authorization. However, this is an ER visit following a recent fall and should not require an authorization

Amount in Dispute: $3,984.50

Respondent's Position

...since the medical treatment of that incident occurring one week earlier, would not indicate the service on July 31, 2021 was an emergency. Accordingly, the provider was required to request preauthorization which the provider failed to do.

Response submitted by: Flahive, Ogden & Latson

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 §133.2 defines a medical emergency.

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

Denial Reasons

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

- D48 – Payment denied/reduce for absence of or exceeded referral
- P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

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

Findings

1. The requestor is seeking reimbursement of out-patient emergency room services rendered in July 2021. The insurance carrier denied for lack of prior authorization. DWC Rule 28 TAC §134.600 (p) states in pertinent part, non-emergency health care requiring preauthorization includes outpatient surgical or ambulatory surgical services.

   The requestor states in their position statement that the ER visit should not require and authorization. Review of the submitted medical record found the claimant fell down six steps a week prior to the emergency room visit.

   DWC Rule 133.2 (5) 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 function in serious jeopardy.

   The medical record indicates the "Acuity" was non-urgent and the pain rating was six. The definition of emergency was not met. The insurance carrier's denial is supported.

   Rule §134.600 (p) requires non-emergency health care to receive prior authorization.

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

		November 5, 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 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.