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

Requester Name
Mark Howard Henry

Respondent Name
Association Casualty Insurance Co

MFDR Tracking Number
M4-22-0324-01

Carrier's Austin Representative
Box Number 53

MFDR Date Received
October 15, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 7, 2021	15240	$2202.84	$0.00
May 7, 2021	15004	$740.04	$0.00
		$2942.88	$0.00

Requester's Position

The healthcare provider's position on this claim is that this date of service has been partially denied. We find one of the charges on this claim has not been paid at 100% of the statutory fee as required by law per Texas Administrative Code title 28 Part 2 Chapter 134 Subchapter C Rule 134.202. The attached medical records adequately support each of the services provided and is sufficient to warrant payment as set forth by the aforementioned section of the Texas Administrative Code.

Amount in Dispute: $326.13

Respondent's Position

It is the Carrier's position the services provided on 05-07-2021 were not related to an emergency, as defined by 28 TAC 133.2(5), and therefore required pre-authorization as required by 28 TAC 134.600.

Response Submitted by: HoffMan Kelley Lopez LLP

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 §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.2 defines medical emergency.

Denial Reasons

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

- 197 – Precertification/authorization/notification absent
- 930 – Pre-authorization required, reimbursement denied

Issues

1. Is the insurance carrier's denial supported?

Findings

1. The requestor is seeking additional reimbursement of outpatient hospital physician services rendered on May 7, 2021. The insurance carrier denied the service for lack of prior authorization. DWC Rule 134.600(p)(2) states in pertinent part non-emergency health care requiring preauthorization includes outpatient surgical or ambulatory surgical services.

   The requestor states in their position statement, "The injured worker's medical condition has been determined to be a medical emergency…"

   DWC Rule 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 position that the services rendered were a medical emergency as defined by 28 TAC §133.2. As a result, the disputed service are non-emergency outpatient services and did require prior authorization. The insurance carrier's denial is supported. No payment can 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 additional reimbursement for the disputed services.

Authorized Signature

		December 10, 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 512-804-4812.