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
M4-22-0325-01

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
April 12, 2021	15240	$2202.84	$0.00
April 12, 2021	20680	$1172.50	$0.00
April 12, 2021	20680	$1172.50	$0.00
April 12, 2021	20680	$1172.50	$0.00
April 12, 2021	11043	$431.88	$0.00
April 12, 2021	73140	$90.89	$0.00
		$6243.11	$0.00

Requester's Position

The attached medical records adequately support each of the services provided and is sufficient to warrant payment… The injured worker's medical condition has been determined to be a medical emergency as defined in the Texas Administrative Code.

Amount in Dispute: $6243.11

Respondent's Position

It is the Carrier's position the services provided on 04-12-2021 were not related to an emergency, as defined by 28 TAC 133.2(5), and therefore require pre-authorization as required by 28 TAC 134.600.

Response Submitted by: Hoffman Kelley Lopez LLP

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 §134.600 sets out the requirements of prior authorization.
3. 28 TAC §133.2 defines medical emergency.

Issues

1. Did the requestor meet the definition of medical emergency?
2. Was prior authorization required?

Findings

1. The requestor is seeking reimbursement of professional medical services rendered in April 12, 2021. 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.
2. The submitted medical bill indicates place of service 22 or On Campus-Outpatient Hospital. DWC Rule 28 §134.600 (p) (2) states in pertinent part non-emergency health care requiring preauthorization includes outpatient surgical or ambulatory surgical services

   Review of the submitted document found insufficient evidence to support the required prior authorization was requested or obtained.

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 20, 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.