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
MHHS Hermann Hospital

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-22-0350-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
October 20, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 29 – 30, 2021	Inpatient Stay	$146,592.00	$0.00
	Total	$146,492.00	$0.00

Requestor's Position

This is an inpatient stay and the patient was admitted the same day after surgery for a 1 day inpatient stay. This bill is being denied for no authorization by Texas Mutual as this was an emergency admit.

Amount in Dispute: $146,592.00

Respondent's Position

The documentation on file confirms and supports MHHS Hermann Hospital requested pre-authorization for out-patient treatment only. The facility submitted a bill for inpatient services, which included a 1-day length of stay that was not preauthorized. Texas Mutual denied the bill appropriately with 240 – no preauthorization obtained.

Response Submitted by: Texas Mutual Insurance Company

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 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:

- 240 – The health care provider requested preauthorization for outpatient treatment …there is no authorization for an inpatient admission appeal-outpatient treatment only requested, no authorization for inpatient admission
- P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Is the requestor's position regarding an emergency supported?

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

Findings

1. The requestor is seeking reimbursement of inpatient hospital services rendered in April 2021. The requestor states, "this was an emergency admit."

   Review of the submitted documentation found the authorization request submitted was for outpatient treatment. Review of the operative report found "Patient tolerated procedure well, was in recovery awake and stable…"

   DWC Rule 133.2 (5) defines an 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 submitted medical record does not support the definition of an emergency. The requestor's position is not supported.

2. The insurance carrier denied the disputed claim based on lack of preauthorization. DWC Rule 134.600 (p) (1) states, "Non-emergency health care requiring preauthorization includes inpatient

hospital admissions, including the principal scheduled procedure(s) and the length of stay."

The submitted prior authorization was for outpatient health care not inpatient health care. The insurance carrier's denial is supported. No 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

		November , 2021
Signature	Medical Fee Dispute Resolution Officer	Date
		November 16, 2021
Signature	Medical Fee Dispute Resolution Director	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.