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
St Joseph Medical Center

Respondent Name
Federal Insurance Co

MFDR Tracking Number
M4-22-0394-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
October 28, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 8, 2021	Outpatient Procedure	$3,433.05	$0.00
	Total	$3,433.05	$0.00

Requestor's Position

The itemized statement was attached to the appeal per payer request. I have attached our notes to show that we spoke to Emma K. with Precertification and authorization is not required for this procedure.

Amount in Dispute: $3,433.05

Respondent's Position

CorVel attests the requestor, St Joseph Medical Center failed to prove in this case that the requirements of rule §134.600(p)(2) were met.

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 TAC §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 emergency.

Denial Reasons

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

- 197 – Payment adjusted for absence of precert/preauth
- W3 – Appeal/Reconsideration

Issues

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

Findings

1. The requestor is seeking reimbursement of outpatient hospital services rendered in April 2021. The requestor states an exception to prior authorization exists as the procedures were done in an emergent situation.

   DWC Rule §133.2 (5) (A) states in pertinent part a medical emergency is 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 injured worker was seen in the physician's office on April 6, 2021. The disputed outpatient service was preformed on April 8, 2021. The history and physical reports moderate stiffness. The submitted documentation does not support sudden onset manifested by acute symptoms required of Rule 133.2(5)(A).

   DWC Rule §134.600 (p) (2) states in pertinent part non-emergency health care requiring preauthorization includes outpatient surgical or ambulatory surgical services.

   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

Signature	Medical Fee Dispute Resolution Officer	December 22, 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.