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
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-22-1077-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
February 4, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 12, 2021	Outpatient Hospital Service	$5,664.66	$0.00

Requestor's Position

This bill was denied for lacking authorization. This procedure was considered an emergency.

Amount in Dispute: $5,664.66

Respondent's Position

This claim is in the WorkWell, TX network and absent an emergency, the rendered services require preauthorization per Rule 134.600(p), which the provider did not obtain.

Response Submitted by: Texas Mutual Workers Compensation Insurance

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 emergency.

3. 28 TAC §134.600 sets out requirements for preauthorization, concurrent utilization review, and voluntary certification of health care.

Denial Reasons

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

- CAC-P12 Workers Compensation Jurisdictional Fee Schedule adjustment
- CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
- CAC-197 – Precertification/authorization/notification absent
- 225 – The submitted documentation does not support the service being billed. We will re-evaluatethis upon receipt of clarifying
- 714 – Accurate license, CPT/HCPCS, Dates, Units, days supply, modifiers are essential for reimbursement submit corrections w/95 days from DOS
- 786 Denied for lack of preauthorization or preauthorization denial in accordance with the network contract

Issues

1. Is Insurance Carrier's denial of payment supported?

Findings

1. The requestor seeks reimbursement of outptatient hospital services rendered on April 12, 2021. The insurance carrier denied the disputed service with denial reduction code CAC-197 and 786 (see reasons listed above). The requestor indicates procedure was considered an emergency.

   28 TAC §134.600 (p)(2) states in pertinent part non-emergency outpatient surgical or ambulatory surgical services require prior authorization.

   28 TAC §133.2 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

   (i) placing the patient's health or bodily functions in serious jeopardy, or

   (ii) serious dysfunction of any body organ or part;

Review othe submitted records does not support the definition of emergency. The DWC finds that the insurance carrier's denial reason is supported, and that preauthorization was required and not obtained. As a result, reimbursement cannot be recommended for the outpatient services in dispute.

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

[redacted]	[redacted]	June 08, 2022
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.