

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Texas Spine and Joint Hospital

Respondent Name

Insurance Co of the State of PA

MFDR Tracking Number

M4-23-1078-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

January 10, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 12, 2022	99281	\$304.00	\$0.00
Total		\$304.00	\$0.00

Requestor's Position

"Our position is the facts and circumstances surrounding this date of service meet the emergency exception which excludes the Hospital from the authorization requirement."

Amount in Dispute: \$304.00

Respondent's Position

"The provider claims that the services were emergency services some 25 years post injury. The carrier's position is that the services were not emergency services and that those services required preauthorization. Since preauthorization was not requested, it follows that there is an absence of a preauthorization approval of the services in question. Since the services required preauthorization, the provider is not entitled to reimbursement."

Response submitted by: Flahive, Ogden & Latson

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 reduced or denied the disputed service(s) with the following claim adjustment codes.

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 197 – Payment denied/reduced for absence of precertification/authorization

Issues

1. Did the respondent raise a new issue?
2. Is the respondent's position supported?

Findings

1. The requestor is seeking reimbursement for emergency room visit in August 2022, The insurance carrier denied based on lack of authorization. The respondent states in their position statement, "The carrier has file a PLN11 disputing the relationship between the medical treatment and the July 21, 1997 date of injury. The Medical Review Division should dismiss the provider's request for medical fee dispute resolution on the basis of a relatedness dispute."

DWC Rule 28 TAC §133 (d)(2)(F) states in pertinent part the response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

Review of the submitted documentation found no denial for relatedness was present as a denial reason to the requestor. The respondent's position statement will not be considered in this review.

2. The insurance carrier denied the disputed service based on lack of prior authorization. DWC Rule 28 TAC §134.600 (p)(2) states in pertinent part, non-emergency health care requiring preauthorization includes outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section.

The requestor states, "Our position is the facts and circumstances surround this date of service meet the emergency exception which excludes the Hospital from the authorization requirement."

DWC Rule §134.600 (c) (1) (A) states in pertinent part, the insurance carrier is liable for all reasonable and necessary medical costs relating to the health care listed in subsection (p) or (q) of this section only when the following situations occur an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions.

DWC Rule §133.2 (5) (A) (i)(ii) defines an emergency as, Emergency--Either a medical or mental health emergency as follows:

(A) 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:

- (i) placing the patient's health or bodily functions in serious jeopardy, or
- (ii) serious dysfunction of any body organ or part;

Review of the submitted medical record states, "The patient reports on 8/08/2022 he began having severe left low back pain." The disputed date of service is December 12, 2022.

The DWC review finds the sudden onset of the condition is not supported.

As the definition of emergency is not met, authorization was required but not obtained. 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

February 28, 2023

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.