TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
WEST GRAY CENTER FOR SPECIAL SURGERY

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-23-1774-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
March 20, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 29, 2022	20680, 15220, 11042, 76000, 64450 and 99070	$131,842.32	$0.00
	Total	$131,842.32	$0.00

Requestor's Position

"This claim was denied by AS&G for lack of pre-authorization. The patient had emergency surgery at our facility, West Gray Center for Special Surgery on 08/25/2022 and the claim was paid by AS&G, patient had a second surgery on 9/29/2022 which was also an emergency due to infection. We contacted AS&G representative, Taskin for pre-authorization and were told after emergency surgery on 08/25/2022 we can treat patient up to 90 days."

Amount in Dispute: $131,842.32

Respondent's Position

"The provider asserts no preauthorization was needed since the procedure to address the claimant's [injury] was a medical emergency. If the procedure was an emergency per Rule 133.2, the treatment would have been performed on the same date of service the patient was seen, which was not the case. On page 20 of the DWC-60 packet, the medical documentation shows the injured worker was seen by Dr. Baher Maximos on 9/28/22 with no indication that an emergency surgery was needed. Also, the health care provider had attempted to obtain preauthorization for the procedure 10 days prior to surgery further showing the procedure was not a medical emergency… Texas Mutual maintains its position that no payment is due. Health care providers can refer to network preauthorization requirements…"

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 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Insurance Code (TIC) §1305.004 defines terms related to workers' compensation health care networks.
3. TIC §1305.006 establishes insurance carrier liability for certain out-of-network health care.
4. TIC §1305.153 sets out general provisions related to provider reimbursement.
5. TIC §1305.351 sets out requirements for utilization review of network health care.
6. 28 TAC §133.2 defines words and terms related to medical bill processing.
7. 28 TAC §134.600 sets out the guidelines for preauthorization, concurrent utilization review, and voluntary certification of health care.

Denial Reasons

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

- 197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
- 786 – DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN ACCORDANCE WITH THE NETWORK CONTRACT.

Issues

1. Are the services eligible for medical fee dispute resolution?
2. Did the requestor meet the definition requirements of a medical emergency?
3. Was preauthorization required?
4. Is the Requestor entitled to reimbursement?

Findings

1. The facility making the request for dispute resolution provided services to an injured worker who was enrolled with a workers' compensation health care network certified under TIC chapter 1305. The requestor does not participate in that network. According to the exception set forth by Insurance Code 1305.006 (1), which mandates that an insurance carrier that forms or enters into a network be liable for emergency out-of-network health care.

   The provider requested medical fee dispute resolution in accordance with 28 TAC §133.307, pursuant to the exception provided by Insurance Code §1305.006 (1) requiring an insurance carrier that establishes or contracts with a network be liable for emergency out-of-network health care.

   The division's Medical Fee Dispute Resolution (MFDR) section has authority to review such disputes in accordance with Insurance Code §1305.153(c), which requires that "Out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation."

   The Texas Workers' Compensation Act and division rules are used to review this dispute.

2. The requestor asserts, "The injured worker's medical condition has been determined to be a medical emergency as defined in the Texas Administrative Code."

   Insurance Code §1305.351(c) states that, "A network or an insurance carrier may not require preauthorization of treatments and services for a medical emergency."

   Insurance Code §1305.004(a)(13) 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: (A) placing the patient 's health or bodily functions in serious jeopardy; or (B) serious dysfunction of any body organ or part."

   This is in line with division Rule §133.2(5)(A), which 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: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part."

The insurance carrier argues: "On page 20 of the DWC-60 packet, the medical documentation shows the injured worker was seen by Dr. Baher Maximos on 9/28/22 with no indication that an emergency surgery was needed. Also, the health care provider had attempted to obtain preauthorization for the procedure 10 day prior to surgery further showing the procedure was not a medical emergency."

A review of the clinical notes was conducted to determine if the requestor documented a "medical emergency" as defined by Rule §133.2.

A review of the clinical note dated 9/19/2022 under "Plan" states in pertinent part, "Will proceed with full thickness skin graft to cover open wound. Surgery is offered. . . Discussed the planned surgical procedure with patient. . ."

The clinical note dated 9/28/2022, one day prior to the procedure, was reviewed and finds that the requestor did not document an "Objective," "Assessment," and a "Plan," as a result the clinical note was insufficiently documented, and the division was unable to determine if a medical emergency had occurred.

According to the operative report for the disputed date of service, 9/29/2022, "The patient Underwent a traumatic injury with a high-pressure machine with an open wound that was treated with washout and debridement and the application of skin substitute. He has an open wound which is infected. This requires immediate washout and coverage to prevent bone necrosis and osteomyelitis."

The surgeon did not draw any conclusions about the need for urgency or note that serious harm would result from delaying treatment. The medical record fails to make it evident that the wounded employee's health, organs, or other body components would be seriously jeopardized or dysfunctional if emergency medical assistance was not provided.

The division found that the provider failed to document a "sudden onset of a medical condition manifested by acute symptoms of sufficient severity and that 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." As a result, the requestor has not documented a medical emergency as defined by Rule §133.2, therefore, preauthorization was required for the procedure performed on 9/29/2022.

3. The insurance carrier denied the disputed services with claim adjustment reason codes:

   - 197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT
   - 786 – DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN ACCORDANCE WITH THE NETWORK CONTRACT.

   The respondent states, "Absent an emergency preauthorization was required but not obtained."

TIC §1305.351 (c) requires that, "If a network or carrier uses a preauthorization process within a network, the requirements of this subchapter and commissioner rules apply."

The division's preauthorization rule, 28 TAC §134.600(p)(2) states that non-emergency health care requiring preauthorization includes: "…outpatient surgical or ambulatory surgical services"

The disputed services are outpatient surgical procedures. As stated above, the submitted records do not support a medical emergency. Accordingly, preauthorization was required. The carrier's denial reasons are therefore supported.

4. Rule §134.600(c)(1) requires insurance carriers to be liable for the cost of non-emergency health care only when "preauthorization of any health care listed in subsection (p) … was approved prior to providing the health care."

   In summary of the findings above, a medical emergency was not supported; preauthorization was therefore required to perform outpatient surgery, however, was not obtained for the disputed services. Consequently, the insurance carrier is not liable for payment. Reimbursement cannot be 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 reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement in the amount of $0.00.

Authorized Signature

		September 29, 2023
Signature	Medical Fee Dispute Resolution Officer	Date
		September 29, 2023
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.