



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Houston Orthopedic & Spine Hospital

Respondent Name

Texas Mutual Insurance

MFDR Tracking Number

M4-13-0512-02

Carrier's Austin Representative

Box Number 54

MFDR Date Received

October 22, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "PT was in extreme pain due to the injury sub stained by working for Local Union 51."

Amount in Dispute: \$174.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the level of care does not rise to the level of emergency as defined by Rule 133.2. No payment is due."

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 28, 2012	Outpatient Hospital Services	\$174.50	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.2 defines an emergency.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W1 – Workers compensation state fee schedule adjustment.
 - 899 – Documentation and file review does not support an emergency in accordance with Rule 133.2
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

- Does the disputed service(s) meet the definition of emergency service?
- Is the requestor entitled to reimbursement?

Findings

- 1. The insurance carrier denied disputed services with reason code, 899 – “Documentation and file review does not support an emergency in accordance with rule 133.2”. 28 Texas Administrative Code §133.2(4)(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: (i) placing the patient’s health or bodily function in serious jeopardy, or (ii) serious dysfunction of any body organ or part.” Review of the submitted medical documentation finds:
 - a. Emergency Physician Record; “onset 5 -7 days ago”
 - b. Quality: “sharp, throbbing, aching”

The Division concludes the Carrier’s denial is supported.

- 2. Definition of medical emergency as defined by Rule 133.2 was not met. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$0.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March , 2015 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.