TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
BAYLOR, SCOTT & WHITE
MEDICAL CENTER LAKE POINTE

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-19-2112-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
December 11, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am requesting a full review for payment."

Amount in Dispute: $1,561.47

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual declined to issue payment as the documentation of the treatment failed to substantiate an emergency as defined by Rule 133.2(a)(4)(A)."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
April 18, 2018	Outpatient Hospital Services	$1,561.47	$0.00

FINDINGS AND DECISION

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

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the hospital facility fee guideline for outpatient services.
3. 28 Texas Administrative Code §133.2 defines words and terms related to medical bill processing.
4. Texas Labor Code §408.021 establishes an injured employee's entitlement to medical benefits.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION.
   - 18 – EXACT DUPLICATE CLAIM/SERVICE
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
   - 242 – NOT TREATING DOCTOR APPROVED TREATMENT.

- 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
- 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824
- 736 – DUPLICATE APPEAL. NETWORK CONTRACT APPLIED BY TEXAS STAR NETWORK. CALL 800-381-8067 FOR RECONSIDERATION DISCUSSION.
- 899 – DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2
- B7 – THE PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE.
- P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issue

Are the insurance carrier's reasons for denial of payment supported?

Findings

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

- 242 – NOT TREATING DOCTOR APPROVED TREATMENT.
- 899 – DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2

Texas Labor Code §408.021(c) requires that, except in an emergency, all health care must be approved or recommended by the employee's treating doctor.

28 Texas Administrative Code §133.2(5)(A), 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 division notes the rule does not require the patient to actually *be* in jeopardy or *suffer* serious dysfunction. It is only required that the patient manifest acute *symptoms* of sufficient severity (including severe pain) that turning the patient away, without evaluation or treatment, could *be expected* (prior to rendering care and *without benefit of hindsight*) to result in serious jeopardy or dysfunction if treatment were not provided.

No information was presented to support that the injured employee was referred by the treating doctor.

Review of the medical record finds no documentation to support the symptoms were either acute or severe.

The nurse's notes state the patient's pain started "about 3 weeks" prior. Later notes state the patient "Reports pain … since falling 1 year ago." Triage assessment states, "Appears in no apparent distress, comfortable . . ."

The physician's examination documented "Severity of symptoms: At their worst the symptoms were moderate …"

No documentation was found to support any expectation that the absence of medical attention could result in serious jeopardy to the patient's health or function or could result in serious dysfunction of any body part or organ.

Because treatment was not shown to be approved or recommended by the injured employee's treating doctor, and because an emergency was not supported by the medical record, the insurance carrier's denial reasons are supported. Payment cannot be recommended.

Conclusion

The division emphasizes that the findings in this decision are based on the evidence presented by the requestor and respondent available at the time of review. Even though not all the evidence was discussed, it was considered.

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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	January 11, 2019
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 in accordance with Rule §133.307.

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 form's instructions. The division must receive the request within twenty days of your receipt of this decision. The request may be faxed, mailed or personally delivered either to the division, using the contact information listed on the form, or to the field office handling the claim.

The party seeking review must deliver a copy of the request to all parties involved in the dispute at the same time the request is filed. Include a copy of this *Medical Fee Dispute Resolution Findings and Decision* together with any other information required by 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.