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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

Requestor Name
BAYLOR UNIVERSITY MEDICAL CENTER

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-19-2890-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
January 25, 2019

## *REQUESTOR'S POSITION SUMMARY*

Requestor's Position Summary: "Patient was seen at Baylor University Medical Center as an emergency visit."

Amount in Dispute: $335.21

## *RESPONDENT'S POSITION SUMMARY*

Respondent's Position Summary: "This was not an emergency as defined by Rule 133.2 … "

Response Submitted by: Texas Mutual Insurance Company

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Dispute Amount | Amount Due |
|---|---|---|---|
| August 24, 2018 | Emergency Department Services | $335.21 | $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 §133.2 defines words and terms related to medical bill processing.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. Texas Labor Code §408.021 establishes an injured employee's entitlement to medical benefits.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 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.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 225 – PENALTY OR INTEREST PAYMENT BY PAYER
   - 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.
   - 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824

## Issues

Does the submitted documentation support a medical emergency?

## Findings

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

- 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.
- 242 – NOT TREATING DOCTOR APPROVED TREATMENT.

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."

Rule §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.

This dispute regards emergency department services. Review of the submitted documentation finds no information to support that the disputed medical services were approved or recommended by the injured employee's treating doctor.

Even though the injured employee presented to an emergency department, the disputed services do not constitute a medical emergency as defined in Rule §133.2(5)(A) above.

The symptoms were not acute or documented as involving a sudden onset, but were rather described as "chronic," persisting for at least two months prior to the employee seeking treatment from this facility.

The medical record states the patient was "in no acute distress" and "Risk factors: none."

The physician notes also: "Severity of pain: At its worst the pain was moderate in the emergency department the pain is unchanged" and noting further that "The patient has experienced similar episodes in the past, chronically."

The nurse's notes document that the patient's pain level "is acceptable."

Based on the submitted medical record, the division concludes the medical provider failed to document symptoms of sufficient severity (including pain) to support that the absence of medical attention could reasonably be expected to result in serious jeopardy or dysfunction to the injured employee's health or body.

Because the health care provider failed to support a medical emergency or that the treatment was approved or recommended by the employee's treating doctor, the insurance carrier's denial reasons are supported. Consequently, 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 | February 22, 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.