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 MEDICAL CENTER CARROLLTON

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-19-3836-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
April 18, 2019

Response Submitted By
Texas Mutual Insurance Company

REQUESTOR'S POSITION SUMMARY

"Claim had denied by Texas mutual insurance stating; documentation does not support the services billed. Not treating Doctor approved."

RESPONDENT'S POSITION SUMMARY

"documentation did not support emergency treatment was rendered as per definition of Rule 133.2"

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
October 2, 2018	Outpatient Hospital Services	$548.32	$0.00

AUTHORITY

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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 §133.2 defines words and terms related to medical bill processing.
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.
   - 16 – CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION.
   - 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
   - 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 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 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

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

Findings

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

- 899 – DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2
- 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." No information was presented to support that the disputed services were approved or recommended by the injured 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.

Although the disputed service is an Emergency Room evaluation, review of the submitted documentation finds insufficient information to support a medical emergency in accordance with the definition in Rule §133.2(5)(A).

The medical records do not note any symptoms of sufficient severity to support that the absence of immediate medical attention could result in serious jeopardy to the injured employee's health or bodily functions or serious dysfunction of any body part or organ.

The employee reported symptoms of pain, but the pain was documented as moderate, not severe. There is a note regarding abnormal vital signs, but the only vital sign or symptom mentioned is "hypertensive" without notation of the severity level. Nowhere in the submitted medical records could be found a notation regarding concern for any serious jeopardy to the patient's health or function, or of any risk of serious dysfunction to a body part or organ.

Because the health care was not approved by the treating doctor and because the medical records do not document a medical emergency, the insurance carrier's denial reasons are supported. Payment cannot be recommended.

Conclusion

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

ORDER

In accordance with Texas Labor Code §413.031, based on the information submitted for review, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	May 16, 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.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). 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 field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute 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.