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
ADVENTIST HEALTH SYSTEM SUNBELT

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-19-4617-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
June 24, 2019

Response Submitted By
Texas Mutual Insurance Company

REQUESTOR'S POSITION SUMMARY

"Please note that patient was treated for chronic back pain related work comp injury, and patient sought medical treatment due to back muscle spasms."

RESPONDENT'S POSITION SUMMARY

"no evidence that the treating or referring Doctor referred the patient to the Emergency Department…. The bill was denied as documentation does not support an emergency."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
December 10, 2018	Emergency Department Treatment	$1,858.57	$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 §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. 28 Texas Administrative Code §134.600 sets out requirements regarding authorization of health care.
5. Texas Labor Code §408.021 establishes an injured employee's entitlement to medical benefits.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 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.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 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.
   - 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION
   - 899 – DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2

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

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 services involve Emergency Room treatment, 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 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. In fact, the exam notes state, "No concerning symptoms for more severe pathology…" as well as "Risk factors consist of none."

The employee presented with symptoms of pain, but the pain was noted as moderate, not severe. The pain was also documented as "chronic," as opposed to "acute" (a criterion of the definition above). Nowhere in the medical record was any concern noted of the potential for serious jeopardy to the patient's health, function, body parts or organs.

Because there was no evidence to support referral by the treating doctor and because the medical records do not document an emergency, the insurance carrier's denial reasons are supported. Payment cannot be recommended.

Conclusion

The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered. For the reasons above, the division finds 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	July 26, 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.