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**
Texas Regional Medical Center

**Respondent Name**
Texas Mutual Insurance Co

**MFDR Tracking Number**
M4-20-0167-01

**Carrier's Austin Representative**
Box Number 54

**MFDR Date Received**
September 18, 2019

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Please note that authorization is not required for emergency room visit, which patient was treated for sever back pain."

**Amount in Dispute:** $988.95

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Absent a medical emergency, this network claim required out of network authorization to treat."

**Response Submitted by:** Texas Mutual

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| November 8, 2018 | 99283 | $988.95 | $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. Texas Labor Code, Chapter §1305.006 outlines the insurance carrier's liability for out-of-network healthcare.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service
   - 272 – Not treating doctor approved treatment
   - 899 – Documentation and file review does not support an emergency in accordance with Rule 133.2

**Issues**

1. Is the insurance carrier's position statement supported?
2. Did the out-of-network healthcare provider meet the requirements of Chapter §1305.006?

**Findings**

1. The requestor billed for emergency room services to an injured employee enrolled a certified healthcare network. The requestor states, "…authorization is not required for emergency room visit…"

   28 TAC 133.2 (5)(1) states 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 placing the patient's health or bodily functions in serious jeopardy, or serious dysfunction of any body organ or part;

   Review of the submitted documentation found;
   - The patient presents with back pain
   - Onset was 3 weeks ago
   - The degree at present is moderate
   - Risk factors consist of none

   Based on the above, the requestor's statement is not supported. The applicable Division Rule applicable to certified networks is found below.

2. The insurance carrier denied the disputed charges as "CAC-B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service," "CAC-242– Not treating doctor approved treatment."

   The authority of the DWC's medical fee dispute resolution ability to resolve matters involving employees enrolled in a certified health care network, is limited to the conditions outlined in the applicable portions of the Texas Insurance Code (TIC), Chapter 1305 and limited application of Texas Labor Code statutes and rules, including 28 TAC §133.307.

   DWC's MFDR section may address disputes involving health care provided to an injured employee enrolled in an HCN, only if the out-of-network health care provider was authorized by the certified network to do so.

   Review of the submitted documentation finds that the requestor submitted insufficient documentation and/or no documentation to support that a referral was obtained from the treating doctor and approved by the network to treat the injured employee.

   Consequently, the services in dispute are not eligible for medical fee dispute resolution pursuant to 28 TAC §133.307.

**Conclusion**

For the reasons stated above, DWC 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, DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

**Authorized Signature**

| | | |
|---|---|---|
| | | October 24, 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, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC using the contact information listed on the form or to the field office handling the claim.

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

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