



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

Baptist Emergency Hospital

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-20-1620-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

February 27, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please review the information below as the insured, considered a "prudent layperson", and determined the illness and/or condition was sever enough to go to the nearest emergency room."

Amount in Dispute: \$705.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: None submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 15, 2019	Outpatient Hospital Services	\$705.30	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.302 defines emergency.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 899 – Documentation and file review does not support an emergency in accordance with Rule 133.2
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

Is the insurance carrier’s denial of payment supported?

Findings

The requestor is seeking reimbursement of emergency room services rendered in August 2019 that were denied by the insurance carrier as definition of emergency not met.

28 TAC §133.2 states in pertinent part a medical emergency is the **sudden onset** of a medical condition manifested by acute symptoms of sufficient severity, including severe pain,

Review of the submitted medical record found, “Date and time of onset was [REDACTED], Symptoms are worsening.”

The date of service in dispute is August 15, 2019. This date is three weeks after the reported date of onset. The sudden onset requirement of the applicable DWC rule is not met.

The insurance carrier’s denial is supported.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. 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 requestor has not established payment 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

Signature	Medical Fee Dispute Resolution Officer	April 30, 2020 Date
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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.

