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

Texas Health Fort Worth

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-20-2413-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

June 4, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…we are requesting all the Q's be paid at the 200% of the allowable in attempt to get thee carriers to stop taking reductions for no reason."

Amount in Dispute: $4,225.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Review of the documentation for visit confirms differential diagnosis pain is related to herniated disc, review of symptoms notes no concerning symptoms for more sever pathology such as incontinence, radiating pain or numbness. The bill was denied as documentation does not support an emergency."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 20, 2019	Outpatient Hospital Services	$4,225.00	$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. 28 Texas Administrative Code §133.2 defines emergency.
3. 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
   - 225 – The submitted documentation does not support the service being billed. We will re-evaluated this upon receipt of clarifying information

Issues

Is the insurance carrier's denial of payment supported?

Findings

The requestor is seeking reimbursement of $4,225.00 for outpatient hospital services rendered July 20, 2019 stating review of the submitted documentation does not support the definition of an emergency.

28 TAC 133.2 states an emergency is defined as either 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 placing the patient's health or bodily functions in serious jeopardy, or serious dysfunction of any body organ or part. Review of the submitted medical record indicates the injured worker presented in pain that is listed a chronic not a sudden onset. The severity of the pain was not found in the submitted documentation.

Based on this review, the definition of emergency 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	Date
		June 10, 2020

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.