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
Hunt Regional Medical Center

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-20-2670-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
July 13, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is the Hospital's understanding that emergent care is determined medically necessary by the Patient's opinion that the severity of their condition requires emergent care and/or a medical emergency."

Amount in Dispute: $679.71

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill was denied as documentation does not support an emergency per Rule 133.2(5)(A)(i)(ii)."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 31, 2019	Outpatient Hospital Services	$679.71	$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
   - 16 – Claim/service lacks information or has submission/billing error(s)
   - 225 – The submitted documentation does not support the service being billed

Issues

Is the insurance carrier's denial of payment supported?

Findings

The requestor is seeking reimbursement of emergency room services rendered in August 2019. The insurance carrier denied the disputed services as documentation does not support an emergency.

The requestor submitted documentation from the Emergency Room Clinical Report that states, "Chief Complaint: Back Pain. It is described as being severe and in the area of the lower lumbar spine and radiating to the right lower extremity and to the left lower extremity. …Onset was yesterday and it is still present."

The Texas Administrative Code Rule §133.2 (5) 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 onset of the condition being treated was not sudden as it had begun the day before and while the pain was reported as severe, the physical exam portion states the appearance of the claimant was "Alert. No acute distress." 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	August 4, 2020 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.