



# 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**

UT Health Tyler

**Respondent Name**

Tokio Marine America Insurance

**MFDR Tracking Number**

M4-20-2963-01

**Carrier's Austin Representative**

Box Number 47

**MFDR Date Received**

August 13, 2020

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "CPT Code 99284 has not bee [sic] paid."

**Amount in Dispute:** \$331.19

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** The Austin carrier representative for Tokio Marine America Insurance Co is Burns Anderson Jury Brenner who was notified of this medical fee dispute on August 25, 2020. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information

As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 9, 2019	Outpatient Hospital Services	\$331.19	\$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 §134.403 sets out the guidelines for professional services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 150 – Payment adjusted because the payer deems the information submitted does not support this level of service

- 5860 – A more appropriate level was indicated per the records and resources required for the presenting problem per ACEP ED level guidelines
- 5860 - A corrected claim is needed with the correct code, units, and charges for reconsideration
- 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 outpatient hospital services rendered on December 9, 2019. The insurance denied stating the submitted documentation does not support the level of service billed under Code 99284.

28 TAC §134.403 (d) states for coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided.

The description of Code 99284 states - Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.

Review of the submitted medical record found the three components described above were not met. The insurance carrier’s denial is supported no payment is recommended.

**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

October 29, 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.**