



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

Wise Regional Health System

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-21-0619-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

December 4, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: None submitted.

Amount in Dispute: \$2,115.17

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "After the initial denial, the provider did not submit a request for reconsideration with additional documentation to support emergency treatment was rendered."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|-------------------|------------------------------|-------------------|------------|
| February 27, 2020 | Outpatient Hospital Services | \$2,115.17 | \$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 §134.203 sets out the guidelines for professional services.
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 §133.2

Issues

Is the insurance carrier’s denial of payment supported?

Findings

The requestor is seeking reimbursement of outpatient hospital services rendered in February 2020. The insurance carrier denied the disputed service as documentation does not support medical emergency.

28 TAC §133.2 (5) (A) 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, 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; No payment is recommended.

The requestor submitted no position statement or medical records to support or demonstrate how the disputed services met the requirements of the Rule.

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 | December 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.

