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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ANDERSON EMERGENCY PHYSICIANS

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-12-0397-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
OCTOBER 6, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Texas Mutual denied claim as not an emergency on 7/23/11. The patient was treated in the emergency room with chronic back pain. We filed an appeal on 08/31/2011 with ER notes attached but Texas Mutual still denying as not an emergency."

Amount in Dispute: $96.70

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor treated the claimant through the emergency department (ED) on 5/27/11. The claimant drove himself to the ED and was admitted at 9am. He reported pain at 8 of 10 to his low back. He walked to room no. 5 in the ED. A lumbar x-ray was done. It read 'moderate degenerative charges to the spine.' No other imaging studies were performed. No lab work was done. The claimant was given a steroid injection and Vicodin by mouth at 10am. His vital signs were normal. His neuromuscular exam was normal. He was discharged to himself at 1020am…There was nothing about this admission that meets the definition of an emergency per Rule 133.2."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 27, 2011	CPT Code 99283 Emergency Room Visit	$96.70	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 effective July 27, 2008 defined a medical emergency.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-W1-Workers compensation state fee schedule adjustment.
   - 899-Documentation and file review does not support an emergency in accordance with rule 133.2.
   - 724-No additional payment after a reconsideration of services.

- CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Does the submitted documentation support a medical emergency? Is the requestor entitled to reimbursement?

Findings

According to the explanation of benefits, the respondent denied reimbursement for the disputed emergency room visit based upon reason code "899."

28 Texas Administrative Code §133.2(3) states "Emergency--Either a medical or mental health emergency as follows: (A) 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: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part."

The requestor contends that reimbursement is due because the claimant "was treated in the emergency room with chronic back pain."

The respondent indicated that "The claimant drove himself to the ED and was admitted at 9am. He reported pain at 8 of 10 to his low back. He walked to room no. 5 in the ED. A lumbar x-ray was done. It read 'moderate degenerative charges to the spine.' No other imaging studies were performed. No lab work was done. The claimant was given a steroid injection and Vicodin by mouth at 10am. His vital signs were normal. His neuromuscular exam was normal. He was discharged to himself at 1020am."

A review of the submitted medical records does not support a medical emergency as defined by 28 Texas Administrative Code §133.2(3). As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	06/04/2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

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