TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name
Texas Health of Dallas

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-23-2978-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
July 25, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 19, 2023	0450	$443.00	$0.00
	Total	$443.00	$0.00

Requester's Position

"...Texas Health appeal received 5/15/2023 and processed 6/7/2023 as "ORIGINAL DECISION UPHELD DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AND EMERGENCY IN ACCORANCE WITH RULE 133.2". Please review the attached information and reprocess our claim for the additional payment due us for the services provided to the claimant."

Amount in Dispute: $443.00

Respondent's Position

"TEXAS HEALTH PRESBYTERIAN HOSPITAL submitted a bill to Texas Mutual for an emergency room visit. Texas Mutual reviewed the documentation and found no evidence that the treating doctor or referral doctor referred the patient to the emergency department. The facility provided documentation which states body pain and medication refill as the reason for the visit. The provider's assessment indicated the patient denies any numbness, weakness, difficulty walking, bowel/bladder changes, and fever. The provider reviewed previous x-rays; however, no additional testing was done on this date. Patient was instructed to follow up with their PCP. Therefore, the documentation does not support an emergency."

Response Submitted by: Texas Mutual Insurance Company

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.2 sets out the definitions of general rules for medical billing and processing.

Denial Reason(s)

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment code(s):

- CAC-40 – Charges do not meet qualification for emergent/urgent care.
- 899 – Documentation and file review does not support an emergency in accordance with Rule 133.2.
- CAC-W3 & 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- DC4 – No additional reimbursement allowed after reconsideration.

Issues

1. Did the requestor submit documentation to support that the service in dispute was an emergency?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor, Texas Health of Dallas, submitted medical fee dispute M4-23-2978-01 to DWC for resolution pursuant to 28 TAC §133.307. The dispute concerns an outpatient, emergency room visit provided by the requestor on February 19, 2023.

   The insurance carrier denied the disputed service with denial reason "CAC-40 – Charges do not meet qualification for emergent/urgent care."

   The requestor submitted the dispute requesting reimbursement for outpatient facility charges rendered on February 19, 2023. The disputed service is governed by the Texas Labor Code (TLC) legislation and rules, including 28 TAC §133.307.

28 TAC §133.2 (1)(5) (A)(i-ii), states, "(5) 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 has the burden to prove that the service in dispute was provided as emergency care. DWC concludes that the provider failed to meet its burden of proof to establish that the date of service in dispute was emergency care.

2. TAC §133.307(c)(2)(N) requires a position statement including: (i) the requestor's reasoning for why the disputed fees should be paid or refunded, (ii) how the Labor Code and DWC rules, including fee guidelines, impact the disputed fee issues, and (iii) how the submitted documentation supports the requestor's position for each disputed fee issue. The position statement did not explain how the care provided on the dates of service was emergency care and was not sufficient to show that the care provided was for a medical emergency as defined in TAC §133.2. Because the treatment for this date of service was not shown to be emergency care, the insurance carrier is not liable for reimbursement.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered. DWC concludes that the insurance carrier is not liable for the disputed services.

Order

Based on the submitted information, pursuant to Texas Labor Code 413.031, the DWC hereby determines the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 14, 2024 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, call CompConnection at 1-800-252- 7031, Option three, or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed 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.