



Medical Fee Dispute Resolution Findings and Decision General Information

Requester Name

Texas Health Kaufman

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-23-3335-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

August 30, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 6, 2022	0450	\$460.99	\$0.00
Total		\$460.99	\$0.00

Requester's Position

"We are in receipt of a payment of \$0.00, however this claim was underpaid by \$460.99. Our calculations are based on the Medicare outpatient rates for CPT code 99284, which is \$230.49, and the outpatient work comp multiplier is 200% without separate implant reimbursement per rule 134.403, see below), and the total work comp fee schedule allowance is \$460.99, and finally, deducting the payment \$0.00, leaves an unpaid balance due of \$460.99. Furthermore, there is no referenced value-based pricing to be carved out of the reimbursement. Also, per TX guidelines in case of 'Emergency' a authorization is not required for a Emergency Room visit."

Amount in Dispute: \$460.99

Respondent's Position

"Texas Mutual has reviewed the DWC60 submitted by the facility... At this time Texas Mutual maintains its position that treatment billed was not a medical emergency in accordance with Rule 133.2(5)(A)(i)(ii)."

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 payment for the disputed services with the following claim adjustment code(s):

- CAC-40 – Charges do not meet qualification for emergency/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.
- CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.

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 Kaufman, submitted medical fee dispute M4-23-3335-01 to DWC for resolution pursuant to 28 TAC §133.307. The dispute concerns an outpatient, emergency room service provided by the requestor on December 6, 2022.

The insurance carrier denied the facility charges with denial reason "899 – Documentation and file review does not support an emergency in accordance with Rule 133.2."

The requestor submitted the dispute requesting reimbursement for the facility charges rendered on December 6, 2022. 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 the Texas Labor Code 413.031, the DWC hereby determines the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____	_____	November 14, 2024
Signature	Medical Fee Dispute Resolution Officer	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.