TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name
North Houston Surgical Hospital

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-24-2089-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 28, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 14, 2023	15240 and 15004	$31,298.78	$0.00
	Total	$31,298.78	$0.00

Requester's Position

"Your organization has denied this billed stating the services are non-payable due to no prior authorization obtained. Prior authorization is not required when services are rendered for a medical emergency. The injured worker's medical condition has been determined to be a medical emergency as defined in the Texas Administrative Code… Please review the attached supporting documents which is sufficient to warrant payment. We request immediate payment for the above-mentioned claim."

Amount in Dispute: $31,298.78

Respondent's Position

"This claim is in the WorkWell, TX network and absent an emergency, the rendered services require preauthorization per Rule 134.600(p), which the provider did not obtain... If the procedure was an emergency per Rule 133.2, the treatment would have been performed on the same date of service the patient was seen, which was not the case… Additionally, the attached document submitted by the provider titled 'Surgery Scheduling Form' supports the surgery was in fact 'elective', surgery benefits is documented with date 12/06/2023, however the benefits clearly shows that the pre-cert/authorization # was not obtained. Further down, page 2 of the scheduling form, it confirms surgery was scheduled for 12/14/2023, there was

an 8 day gap where the provider had sufficient time to submit a request for preauthorization. Texas Mutual maintains its position that no payment is due"

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. Texas Insurance Code (TIC) Chapter 1305 governs workers' compensation health care networks.

Denial Reason(s)

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

- 197 – Precertification/authorization/notification absent.
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 786 – Denied for lack of preauthorization or preauthorization denial in accordance with the Network contract.
- 895 – 133.210 requires itemized statement for hospital services.
- W3 & 350 – In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 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.
- 786 – Denied for lack of preauthorization or preauthorization denial in accordance with the Network contract.

Issues

1. Is the insurance carrier's reason for denial supported?
2. Is the Requestor entitled to reimbursement?

Findings

1. The requestor, North Houston Surgical Hospital, submitted medical fee dispute M4-24-2089-01 to DWC for resolution pursuant to 28 TAC §133.307. The dispute concerns non-payment of facility charge billed under CPT codes 15240 and 15004, provided by the requestor on December 14, 2023. A review of the submitted documentation finds that the injured employee's claim is within the WorkWell, TX certified network. No documentation was submitted to support that the requestor was in the network at the time the services were rendered. As a result, the requestor provided out-of-network health care to the injured employee.

   The Requestor, having provided out-of-network services, asserts that the care provided was "… rendered for a medical emergency," such that network-based restrictions are inapplicable, and the respondent/carrier is required to pay in accordance with the TLC and DWC rules. A medical fee dispute of this nature is within the jurisdiction of DWC.

2. The requestor submitted the dispute requesting reimbursement for the disputed services as governed by the Texas Labor Code (TLC) legislation and rules, including 28 TAC §133.307. The requirements mentioned in the relevant sections of the TIC, Chapter 1305, are applicable to DWC's ability to apply the TLC legislation and DWC rules for out-of-network health care. TIC §1305.153 (c) provides that "Out-of-network providers who provide care as described by §1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation."

   TIC §1305.006 titled *INSURANCE CARRIER LIABILITY FOR OUT-OF-NETWORK HEALTH CARE* states, "An insurance carrier that establishes or contracts with a network is liable for the following out-of-network healthcare that is provided to an injured employee:

   (1) emergency care;

   (2) health care provided to an injured employee who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract; and

   (3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to §1305.103."

   The requestor therefore has the burden to prove that the exceptions outlined in the TIC §1305.006 were met for the insurance carrier to be liable for the disputed services. The requestor contends that the disputed services were provided for emergency care in TIC §1305.006(1). TIC §1305.006(2) and (3) were not shown to be applicable in this case.

3. DWC concludes that the provider failed to meet its burden of proof to establish that the dates of service in dispute were emergency care. 28 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 were emergency care under TIC §1305.006. Furthermore, for the date of service at issue, the documentation provided was not sufficient to show that the care provided was for a medical emergency as defined in TIC §1305.004(13). Because the treatment for this date of service was not shown to be emergency care, the insurance carrier is not liable for this non-network care under TIC §1305.006.

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

		August 2, 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, please 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.