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

General Information

Requestor Name
North Houston Surgical Hospital

Respondent Name
Old Republic Insurance Co

MFDR Tracking Number
M4-24-2230-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
June 11, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 2, 2024	11043	$31,517.85	$0.00
	Total	$31,517.85	$0.00

Requestor's Position

The requestor submitted a copy of their reconsideration that states, "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."

Amount in Dispute: $31,517.85

Respondent's Position

"Our supplemental response for the above referenced medical fee dispute resolution is as follows: the bills in question were escalated and a review completed. Our bill audit company has determined no further payment is due… Rationale: As the charges were not authorized, the Branch will need to provide the response to the State as the denial states – This service was not pre-authorized in conformance with TWCC Rule 134.600."

Response Submitted by: Gallagher Bassett

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §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) 134.600 sets out requirements of prior authorization.

2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

3. 28 TAC §133.2 defines emergency.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- 31065 – This service was not pre-authorized in conformance with TWCC Rule 134.600
- 5721 – To avoid duplicate bill denial for all reconsiderations/adjustment/additional payment request, submit a copy of this EOR or (illegible).
- 109 – Claim not covered by this payer/contractor. You must send bill to correct payer/contractor.
- 00663 – Reimbursement has been calculated according to State Fee Schedule Guidelines.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Was prior authorization required?

2. Is the requestor's position supported?

Findings

1. The requestor is seeking reimbursement for an outpatient surgical procedure rendered in January 2024. The insurance carrier denied the disputed service based on lack of prior authorization. DWC Rule §134.600 (p)(12)(2) states in pertinent parts, "Non-emergency health care requiring preauthorization includes outpatient surgical or ambulatory surgical services…" Based on the above, prior authorization was required. Exceptions to prior authorization are found in DWC Rule §134.600(c)(1)(A) discussed below.

2. The requestor states "The injured worker's medical condition has been determined to be a medical emergency." DWC Rule §134.600(c)(1)(A) states in pertinent part, "The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care listed

in subsection (p) or (q) of this section only when the following situations occur: An emergency, as defined in Chapter 133 of the title."

DWC Rule 133.2 (5) (A)(i)(ii)(B) 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;

(B) a mental health emergency is a condition that could reasonably be expected to present danger to the person experiencing the mental health condition or another person.

The requestor has the burden to prove that the exception outlined in DWC Rule 28 TAC §134.600 (c)(1)(A) was met for the insurance carrier to be liable for the disputed services.

DWC Rule 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 DWC Rule TAC 28 §133.2(5).

Because the treatment for these dates of service was not shown to be emergency care, prior authorization was required. The insurance carrier's denial is supported.

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 finds the requestor has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		July 25, 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 1-800-252-7031, opción tres o correo electronico CompConnection@tdi.texas.gov.