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
North Houston Surgical Hospital

Respondent Name
Liberty Mutual Fire Insurance Company

MFDR Tracking Number
M4-24-2276-01

Carrier's Austin Representative
Box Number 60

MFDR Date Received
June 14, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 18, 2024	26422	$47,327.87	$0.00
	Total	$47,327.87	$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: $47,327.87

Respondent's Position

"The bill for DOS November 14, 20231 has been reviewed and denial stands as Pre-authorization was required, but not requested for this service per DWC: Rule 134.600. (5917) This has been reviewed and it appears this does not meet the criteria for 'Medical emergency' based on the records provided."

Response Submitted by: Liberty 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 definition of an emergency.

Denial Reason(s)

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

- 5917 – Pre-authorization was required, but not requested for this service per DWC rule 134.600.

Issues

1. Did the facility charges in dispute require preauthorization?

Findings

1. The requestor, North Houston Surgical Hospital requested reimbursement for outpatient surgery charges provided in an outpatient facility on January 18, 2024.

   The requester asserts that preauthorization was not required due to a medical emergency.

   The insurance carrier asserts that the bills were reviewed, and the denial stands as preauthorization was required but not requested. In addition, the treatment does not meet the criteria for medical emergencies.

   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.

   28 TAC §133.2 set out the definition of an emergency.
   (1) 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).

DWC finds that the position statement did not explain how the care provided on the disputed date of service was emergency care under 28 TAC §133.2 The statement and the supporting documentation did not provide a basis or explanation to conclude that the date of service in dispute was emergency care. The provider has therefore failed to meet its burden of proof to establish that the date of service in dispute was emergency care. As a result, DWC finds that the insurance carrier is not liable for the facility charges rendered on January 18, 2024.

For the reasons stated above, DWC concludes that the provider failed to meet its burden of proof to establish that the date of service in dispute was emergency care. 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. T

The position statement did not explain how the care provided on the dates of service were emergency care under 28 TAC §133.2. 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 28 TAC §133.2. Because the treatment for this date of service was not shown to be emergency care, the requestor is not entitled to reimbursement for the outpatient surgery services rendered on January 18, 2024.

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

		October 24, 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.