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
M4-25-0753-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
December 3, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 6, 2024	26546, and 99281	$112,267.45	$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. If we do not receive payment within 60 days from the date of the claims attached. We will seek interest."

Amount in Dispute: $112,267.45

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. The provider asserts no preauthorization was needed since the procedure to address the claimant's [REASON FOR VISIT OR PRIMARY COMPLAINT] was a medical emergency. 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. The injured worker had an x-ray done on 05/03/2024 and the TWCC-73 issued on that date shows the injured worker would be

off work 05/06/24-05/07/24 due to surgery indicating that the surgery was planned and not a true emergency… Texas Mutual maintains its position that no payment is due. Health care providers can refer to network preauthorization requirements at texasmutual.com/provider-preauth."

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):

- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- CAC-W3, 350 – In accordance with TDI-DWC rule 134.804, this bill has been identified as request for reconsideration no appeal.
- CAC-193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
- CAC-197 – Precertification/authorization/notification absent.
- CAC-97 – The benefit for this service is included in the payment allowance for another service/procedure that has already been adjudicated.
- DC4 – No additional reimbursement allowed after reconsideration.
- 217 – The value of this procedure is included in the value of another procedure performed on this date.
- 306 – The implant is included in this billing and is reimbursed at the higher percentage calculation.
- 788 – Denied for lack of preauthorization or preauthorization denial. In accordance with the network contract.

Issues

1. Are the disputed services out-of-network health care?
2. If the disputed services are out of network, is the insurance carrier liable for the disputed services under TIC §1305.006?

Findings

1. The requestor, North Houston Surgical Hospital, submitted medical fee dispute M4-25-0753-01 to DWC for resolution according to 28 TAC §133.307. The dispute concerns outpatient hospital services provided by the requestor on May 6, 2024. Per the submitted documentation and from information known to DWC, the injured employee's claim is within the WorkWell certified healthcare network. The requestor was not in the network at the time of the date of service. 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 "emergency care" 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.

   DWC concludes that the provider failed to meet its burden of proof to establish that the dates of service in dispute were 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.

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 dates 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 these dates 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

		April 9, 2025
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.