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

General Information

Requester Name
Methodist Dallas Medical Center

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-25-1039-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
January 13, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 18, 2024	Rev. Code 450, CPT code 99282	$298.73	$0.00

Requester's Position

"Requesting review of emergency visit denial."

Amount in Dispute: $298.73

Respondent's Position

"METHODIST DALLAS MEDICAL CENTER submitted a bill to Texas Mutual for an emergency department visit on 01/18/2024. Texas Mutual reviewed the documentation and found no evidence that the treating or referral doctor referred the patient to the emergency department. The facility provided documentation which states the injured worker presented for [injury]. The provider's assessment indicated the patient has [injury] and gave a muscle relaxant to the injured worker. Therefore, the documentation does not support an emergency."

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

- CAC-40 – Charges do not meet qualifications for emergency/urgent care.
- 898 – Documentation and file review does not support an emergency in accordance with Rule 133.2.
- CAC-29 – The time limit for filing has expired.
- 731 – Per 133.20(B) provider shall not submit a medical bill later than the 95th day after the date the service.

Issues

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

Findings

1. Methodist Dallas Medical Center (the requester) submitted medical fee dispute M4-25-1039-01 to the Division of Workers' Compensation (DWC) for resolution under 28 TAC §133.307. The dispute concerns an emergency room charge provided by the requester on January 18, 2024.

   Per the submitted documentation and from information known to DWC, the injured employee's claim is within the WorkWell Network. The requester was not in the network at the time of the date of service(s). As a result, the requester provided out-of-network health care to the injured employee. A medical fee dispute of this nature is within the jurisdiction of DWC.

2. The requester's dispute for out-of-network services is 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 requester 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 requester 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 requester'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 requester'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 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.

DWC finds that the requester is not entitled to reimbursement for the emergency room charges in question.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requester 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 requester is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		October 28, 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.