



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Methodist Health Systems

Respondent Name

Indemnity Insurance Co of North

MFDR Tracking Number

M4-25-2827-01

Carrier's Austin Representative

Box Number 15

DWC Date Received

July 9, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 14, 2025 through March 1, 2025	Emergency to inpatient hospital	\$64,467.83	\$0.00

Requestor's Position

"Requesting review of authorization denial. Per RevCode 450, this was an emergency visit/procedure therefore by the Texas Fee Schedule should be granted retroauthorization."

Amount in Dispute: \$64,467.83

Respondent's Position

The Austin carrier representative for Indemnity Insurance Co of North is Downs & Stanford. The representative was notified of this medical fee dispute on July 10, 2025.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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 TAC §133.305](#) sets out the general provisions of medical fee dispute.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
3. [28 TAC §134.600](#) sets out the requirements of prior authorization.

Denial Reasons

The insurance carrier denied the disputed service(s) with the following claim adjustment codes.

- 00663 – Reimbursement has been calculated based on the state guidelines.
- 31065 – This service was not pre-authorized in conformance with TWCC Rule 134.600.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. What rules apply to the disputed charges?
2. Did the requester support their position statement?
3. Is the requester entitled to reimbursement for the services in dispute?

Findings

1. The requester seeks reimbursement for an inpatient hospital stay from February 14, 2025, through March 1, 2025. The insurance carrier denied the claim due to lack of prior authorization. The applicable rules include.
 - 28 TAC §134.600(p)(1): Non-emergency health care requiring pre-authorization includes inpatient hospital admissions, encompassing the principal scheduled procedure(s) and length of stay.
 - 28 TAC §134.600(c): The insurance carrier is liable for all reasonable and necessary medical costs related to health care listed in subsection (p) or (q) only when:
 - (A) an emergency occurs as defined in Chapter 133.
 - 28 TAC §133.2(5): Defines emergency as a sudden onset of a medical condition with acute symptoms severe enough that immediate care is necessary to prevent:
 - (i) serious jeopardy of the patient's health or bodily functions, or
 - (ii) serious dysfunction of any body organ or part.

- 28 TAC §133.307(2)(N): Requires the requester’s position statement to include:
 - (i) reasoning for why the disputed fees should be paid or refunded,
 - (ii) how the Labor Code and Division rules impact the disputed fees, and
 - (iii) how submitted documentation supports the requester’s position for the disputed fee
2. The requester’s position statement asserts, “this was an emergency visit/procedure... the Texas Fee Schedule should be granted retroauthorization.” Medical records indicate the injured worker presented through the emergency room underwent surgery and had a 15-day inpatient stay. However, the requester did not provide evidence that an authorization request was made before or at the time of admission for the ongoing inpatient stay:

Additionally, while the provider claimed the visit was an emergency justifying retroactive authorization, the position statement lacked an explanation of how the care met the emergency criteria under 28 TAC §133.2. The supporting documentation did not substantiate the claim that the disputed services were emergency care. Therefore, the requester failed to sufficiently establish that the disputed services qualified as emergency care.

3. DWC concludes the opinion and supporting documentation do not demonstrate that the disputed dates of service involved emergency care as defined in 28 TAC §133.2. Consequently, the requester did not meet the criteria for reimbursement under this rule, and the insurance carrier is not liable for the disputed services.

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 requester has not established that 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

Signature	Medical Fee Dispute Resolution Officer	August 28, 2025 Date
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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 3 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 3 o correo electrónico CompConnection@tdi.texas.gov.