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

Requestor Name
MHHS HERMANN HOSPITAL

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-22-1193-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
February 17, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 13, 2021	73721	$4,962.50	$0.00
	Total	$4,962.50	$0.00

Requestor's Position

"On 05/13/2021 patient had an MRI because of her ongoing... pain. The hospital was informed on 05/07/2021 by Melissa M at Texas Mutual reference # 1750652 that no authorization was required. I have been advised lo file this as a medical fee dispute. I have attached all available documents for your review."

Amount in Dispute: $4,962.50

Respondent's Position

"Texas Mutual reviewed the dispute submitted by Memorial Herman Hospital for an MRI. Review of the claim file notes, claim file images from preauth department and did not locate any evidence of confirmation # 1750652 by Melissa M as noted in the providers positions statement. Additional research of the claim file does not support that the facility submitted a request for preauthorization on or around 5/7/2021. Health care providers can refer to preauthorization requirements at texasmutual.com/provider-preauth. Our position is that no payment is due."

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 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.600 sets out the fee guidelines for preauthorization, concurrent utilization review, and voluntary certification of health care.

Denial Reasons

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

- CAC-197 - PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
- 930 - PRE-AUTHORIZATION REQUIRED. REIMBURSEMENT DENIED.
- CAC-W3 - IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- CAC-193 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

Issues

Is the Requestor entitled to reimbursement?

Findings

The requestor seeks reimbursement for outpatient radiology services rendered on May 13, 2021. The insurance carrier denied the service in dispute with denial codes, 197 and 930 (descriptions provided above.)

28 TAC §134.600 (p)(2) states, "(p) Non-emergency health care requiring preauthorization includes… (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section…"

The DWC finds that the outpatient service in dispute requires preauthorization. The requestor submitted insufficient documentation to support that preauthorization was obtained for the service in dispute. As a result, reimbursement is not recommended.

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.

The DWC finds the requester has established that reimbursement is not due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to reimbursement for the disputed services.

Authorized Signature

		March 16, 2022
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 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 electronico CompConnection@tdi.texas.gov.