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**
TEXAS VISTA MEDICAL CENTER

**Respondent Name**
TEXAS MUTUAL INSURANCE COMPANY

**MFDR Tracking Number**
M4-23-0230-01

**Carrier's Austin Representative**
Box Number 54

**DWC Date Received**
September 27, 2022

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| March 28, 2022 | Outpatient facility charges | $11,532.85 | $0.00 |
| | **Total** | $11,532.85 | $0.00 |

## Requestor's Position

"This bill and appeal denied for timely filing. It was initially sent to Medicare. Proof has been attached as well as the remit. We are not informed of worker's compensation until 5/10/22."

**Amount in Dispute:** $11,532.85

## Respondent's Position

"This claim is in the Texas Star network and the health care service(s) rendered require preauthorization per Rule 134.600. Texas Mutual has no record that the provider obtained preauthorization. Health care providers can refer to network preauthorization requirements..."

**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 §134.203 sets out the fee guideline for professional medical services.
3. 28 TAC §134.600 sets out the 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-W3 & 350 – 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.
- CAC-197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
- DC4 - NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION.
- 786 - DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN ACCORDANCE WITH THE NETWORK CONTRACT.

Issues

1. Is the Insurance Carrier's denial reason supported?
2. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for outpatient facility charges rendered on March 28, 2022. The insurance carrier denied the disputed services due to lack of preauthorization.

   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."

   Review of the documentation submitted by the parties, does not support that preauthorization was obtained as required per 28 TAC §134.600 (p)(2). The DWC finds that preauthorization was required and not obtained, as a result reimbursement cannot be recommended.

2. The DWC finds that the requestor has not established that reimbursement is due for the services in dispute. As a result, $0.00 is 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 not established that reimbursement is 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**

| Signature | Medical Fee Dispute Resolution Officer | December 19, 2022<br>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.